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ABSTRACT

This document contains articles addressing a variety of psychological and behavioral problems of adolescents and children and is intended as a resource tool for school psychologists. Articles include background information, approaches regarding assessment of the behavior of concern, intervention possibilities, monitoring methods, and references. The articles are: (1) "Firesetting in Children and Youth," by M. Carol Sensor; (2) "Educational Implications of Overdependency," by Lyle J. White; (3) "Chronic Illness in Childhood and Adolescence: Considerations for School Personnel," by Margaret L. Potter; (4) "Stealing," by R. Michael Weger; (5) "Child Sexual Abuse," by Harvey A. Disenhouse; (6) "Sleep Disorders," by Bruno A. Bielat; (7) "Decision Making Quandries for Children and Adolescents," by Deborah A. Hill; (8) Preschool Screening Programs: A Challenge for Decision Makers," by Barry J. Wilson; (9) "Oppositional Behavior," by Mary Grace Percival; (10) "Vandalism and Property Destruction: School Psychological Services to Meet the Challenge," by Stewart Ehly; (11) "Headache - Considerations for the School Psychologist," by Larry Gile; (12) "Shy-Withdrawn Patterns of Behavior," by John C. Polifka and Sharon Polifka; and (13) "Seizure and Convulsive Disorders," by David Happe. (ABL)

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Psychological Approaches to

Problems of Children and Adolescents

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Psychological Approaches to Problems of Children and Adolescents

Editors: Jeff Grimes and Alex Thomas

1985

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FOREWORD

As school psychologists we encounter a variety of complex problems in the behaviors of children and adolescents referred for special services. The problem behaviors may include children and youth who are firesetters, overly dependent, chronically ill, involved in stealing, sexually abused, have difficulties sleeping, can't make decisions, may not be ready for school experience, are oppositional, vandals, experience headaches or are shy and withdrawn. All of these cases occur every year, some frequently, some infrequently, but they are part of the concerns referred to school psychologists. This is Volume II, 14 other topics were included in a previous publication that is now available through ERIC: ED232082.

Each chapter typically includes the following content, background information concerning the specific topic, approaches regarding assessment of the behavior of concern, intervention possibilities, monitoring methods and other considerations. This book is designed as a resource for school psychologists working with these behaviors in a school and home setting.

There are many people whose work has been critical in making this publication possible: the authors have put countless hours into the thoughtful writing of their chapters; secretarial services of Jody Crane, Marcia Stanley and Jeri Crane were invaluable in creating the final version of the text; John Lanham and John Lee for processing accounting data related to the project. It's a combined effort, done for you, the school psychologists who work with the children and adolescents who have special needs. We hope this volume will, in fact, be a useful resource that helps in your successful work with children and youth.

J. G. & A. T.

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Firesetting in Children and Youth

M. Carol Sensor

Abstract: This chapter presents a history of the theories and treatments regarding firesetting. A review of the literature offers background information regarding these children, their families, and their behavior. Several viable treatments are presented with case examples. One prevention program is also discussed.

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Definition, Background and History

History

I hear the alarm at dead of night
I hear the bells - shouts!
I pass the crowd - I run!
The sight of flames maddens me with pleasure.

Walt Whitman (1860)

For over a century poets, philosophers, psychologists, authors, and criminologists, to mention a few, have studied and written about the phenomenon of fire and firesetters. Continuing today fires have many meanings, and references to fire may include associations with such emotions as passion, love, rage, or hate. Fire is a universal symbol of life and death and plays an important role in the religious expressions of these concepts (Kaufman, Heins, & Reiser, 1961).

Fire has not only been used for accepted purposes. The literature, as early as the beginning of the nineteenth century, addressed problems with firesetters. Although the underlying motivational factors reflected in firesetting have long been a point of interest and question, firesetting by children was not specifically studied until Yarnell's 1940 study (cited in Bumpass, Fagelman, & Brix, 1983).

Definition

The third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (1980) includes pyromania under disorders of impulse control and has the following description:

> 312.33 Pyromania
> The essential features include recurrent failure to resist impulses to set fires and intense fascination with setting fires and seeing them burn. Before setting the fire, the individual experiences intense pleasure or release. Although the firesetting results from a failure to resist an impulse, there may be considerable advance preparation for starting the fire, and the individual may leave obvious clues. (p. 294).

To meet the diagnostic criteria of Pyromania, the following must be present:

A. Recurrent failure to resist impulses to set fires.
B. Increasing sense of tension before setting the fire.
C. An experience of either intense pleasure, gratification or release at the time of committing the act.

D. Lack of motivation, such as monetary gain or sociopolitical ideology, for setting fires.
E. Not due to Organic Mental Disorder, Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder. (p. 295)

The DSM-III definition and diagnostic criteria are not focused upon children specifically.

The definition of firesetter has varied greatly in the studies found in the literature. For the purposes here, a firesetter is rather broadly defined as any child or young person who has set a fire. This includes children over age 4 who may have initially been experimenting with matches and the fire was set accidentally as well as the child whose fire is well planned.

Background

In our society nearly all children develop a fascination with fire and experiment with it at a relatively early age. As the average child grows, their curiosity about and experimentation with fire usually diminishes in proportion to their progress toward maturity (French, 1979).

Normal individuals at any age are fascinated by fire. It is a wonderfully destructive, powerful, all-consuming force. Most persons are satisfied to light "safe" fires which are kept under control and are socially approved, such as bonfires and fireplace fires (Shaw, 1966). Some children and adolescents, however, exhibit firesetting behavior that is neither transient nor apparently experimental in nature. These young persons exhibit pathological firesetting.

To further familiarize the reader with this phenomenon, a variety of aspects will be discussed. These include characteristics of the children, their families, and their fires.

Children's Characteristics

Incidence. The studies investigated indicated an incidence rate of 14.3 to 16.5% of the referrals to mental health facilities (Gruber, Heck, & Mintzer, 1981; Heath, Hardesty, Goldfine, and Walker, 1983; Stewart & Culver, 1982). These incidence rates may underestimate the true occurrence of firesetting in society since they were limited to children whose families sought professional help.

Gender. Firesetting appears to be predominantly a male problem. All of the studies reviewed reported samples composed of at least 90% males.

Age. According to Carter (1978), children may begin to set fires with deliberate intent and motives at the developmental age of 4. Several authors addressed differences in the firesetters' behaviors based upon their age/developmental level (Carter, 1978; Stewart & Culver, 1982; Yarnell, cited in Bumpass, et al., 1983). Younger children tended to set fires at home and alone, while the older children experienced more peer interaction and set fires away from home.

Enuresis. The association between firesetting and enuresis was first suggested by Freud (1932). Research results have not established the relationship but nor has it been able to refutiate it. A relationship has been found between enuresis and delinquency in general (Michaels cited in Shaw, 1966). He coined the term "enuresis of impulsivity."

Intelligence and school achievement. Conflicting data have also been generated regarding intellectual functioning and achievement in school. Although the data are inconclusive regarding the intellectual functioning of firesetters, it was observed that brighter children tended to set more fires and to demonstrate firesetting behavior typical of older children. (Heath et al., 1983).

Motives. The children in Lowenstein's (1979) study reported the following common reasons for firesetting:

1. excitation caused by fires
2. enjoyment produced by fires
3. tendency for the child to be accident prone in the process of playing with fire
4. tendency to relieve frustration through firesetting
5. tendency to feel little guilt regarding firesetting

In addition to these motives, conflicts with parents and siblings as well as confrontations with teachers and school personnel have been reported as motives (Carter, 1978).

Reason for referral. Firesetting is not typically an isolated symptom; therefore, the presenting referral problem frequently includes other disruptive behaviors. Many of the studies cited rage reactions, poor school achievement, aggressive behavior, theft, and truancy as reasons for initial referral.

Family Characteristics

The family background of firesetting children has been an area of interest to many researchers. Their investigations have yielded results indicating a history of family turmoil, disruption, and stress. Many of the children came from broken homes and had a history of being the victims of abuse.

The psychological stability of the parents and their parenting skills were found to correlate with firesetting (Fine & Louie, 1979; Stewart & Culter, 1983). The fathers of firesetters were also found to be more frequently absent or unemployed than the fathers of non-firesetters (Strachan, 1981).

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Firesetting Characteristics

The firesetting of children up to age 6 was described as demonstrating little knowledge of what would burn. Igniting and dropping paper into toilet bowls and bathtubs was reported as typical for this age group. Most fires set by these young children were done so at home or in the home of a relative (Carter, 1978). The average age of children who set fires in their own neighborhood was found to be younger than children who set fires away from home (Strachan, 1981; Heath et al., 1983).

Preadolescent fires were found to frequently be accompanied by vandalism, particularly in schools and churches. In general, their fires lacked planning, preparation, or maturity (Carter, 1978). The adolescent, on the other hand, planned their fires and typically set them away from home (Yarnell cited in Bumpass, 1983).

Assessment and Diagnosis

In contrast to other problems children may develop, firesetting is not difficult to diagnose if reported. By the definition presented, children under the age of four would not be considered intentional firesetters. Although the majority of incidents where children play with fire do not represent symptomatic behavior, if the action is repeated or poses a danger of destruction to persons or property, it must be considered pathological and in the need of intervention.

Perhaps one of the most difficult obstacles to overcome in diagnosing a firesetter is the parents. Due to society's reaction to arson, many are reluctant to disclose the problem.

Instrumentation

Lowenstein's 1979 study attempted to differentiate firesetters from non-firesetters on a number of objective instruments. In addition to measures of academic achievement, the Lowenstein Fire-Raising Diagnostic Test (LFRDT) and the Eysenk Personality Questionnaire were administered. Only the LFRDT successfully differentiated between the two groups.

The LFRDT is composed of 12 statements in a true-false format. Half of the statements focus on firesetting while the other half are a lie scale. The measure is comprised of the following statements:

1. I always do what I am told to do.
2. I have started fires because I am angry with someone or something.
3. I have never and would never steal anything from anyone.
4. I have found several times (at least twice) that I could not control the spread of a fire I started.
5. I never lie.
6. I get quite excited when I see a fire burning.
7. I always tidy up every mess I make at once.
8. I don't feel so angry after I see a fire.
9. Even when nobody is looking, I always do the right thing.
10. I like playing with fire.
11. I never break any rules.
12. I don't care how much destruction is caused by fire.

In Lowenstein's sample of 12 firesetters and 12 non-firesetters statements 6 and 10 were found to always be answered as true by the firesetters and never answered true by the non-firesetting children. Two-thirds of the firesetters answered true on statement 8, while none of the non-firesetters answered affirmatively.

The Child Behavior Checklist by Achenback and Edelbrock (cited in Heath et al., 1983) is another measure which has been utilized to determine firesetting. Here, a variety of behaviors are rated as absent, occasional, or frequent by the parents. This instrument provides measures on competency and psychopathology. The competency scale is composed of three scales: activity, social, and school functioning. The psychopathology scale includes factors such as delinquency, depression, and aggression. Second order factors of internalizing and externalizing problem behaviors may also be determined. Heath et al. (1983) found their sample of firesetters to score significantly higher on measures of externalizing (acting-out) behavior and lower on measures of activity.

In addition to the formalized instrumentation, interviews with the child, the parents/guardians, and the school personnel are essential in determining the support systems available and in the selection of the most viable treatment. The number and conditions of the firesetting behavior will determine whether this was an isolated incident or a more chronic problem. The parents' reactions to the behavior and the consequences imposed will yield valuable information in assessing their attitude toward the problem and their cooperation during intervention. The school's attitude and resources will determine whether the child may continue in their setting and what assistance may be provided at school.

Intervention

Because of the severity of this problem and due to its potential danger to the community, the child and his/her parents, firesetting is often an indication for drastic treatment measures. Since firesetting rarely presents itself as an isolated problem, concurrent difficulties are likely to influence the type of intervention utilized. (Kuhnley et al., 1982).

Management and treatment of these cases frequently includes a period of protective inpatient placement for the child (Kaufman et al., 1961). Removal from the home environment to a therapeutic setting usually results in immediate cessation of the firesetting behavior. Not every child needs to be removed from the home, however. Outpatient therapy may be adequate if the problem is minor. A variety of treatments, such as traditional psychotherapy, behavior management, and family therapy, have been reported in the literature both for residential patients and for children on an outpatient basis.

Behavior Management

Stimulus Satiation

Welsh (cited in Schaefer & Millman, 1977) reported the use of stimulus satiation to extinguish the firesetting behavior of a 7 year old boy. The therapist presented the boy with 20 boxes full of small wooden matches and asked if he would like to learn how to properly light them. The boy agreed and was instructed how to close the cover before striking, how to hold the match over an ashtray and how to hold it until he felt its heat on his fingertips and then to blow it out. In the first session of 45 minutes, he went through a box and a half of matches. In the next session, he quickly became restless and was allowed to do something else at the end of the session. He showed no interest in lighting matches at the next session and was allowed to play after striking 10 matches. The parents reported the boy no longer appeared fascinated with fire play at home. He was seen in traditional play therapy for several more months, during which time the firesetting behavior did not return.

Parent-Implemented Program

The study of a 7 year old firesetter was reported by Holland (1969) and supports the use of behavior management by parents to extinguish such behavior in a relatively short period of time.

The young boy, R., set fires at home whenever he found matches and his parents were gone or in bed. Punishments such as being slapped, locked in his room, and touched with a smoldering object were only effective for a short time.

The treatment plan was developed during five sessions with the parents. Due to the mother's skepticism, the father carried out the plan. First R. was told he would lose his highly prized baseball glove if he set any more fires. He was also told to immediately take his father any matches or matchbook covers he found around the house. When R. brought an empty matchbook cover (the father had conspicuously placed on a table), he was immediately given 5 cents and urged to go to the store to spend it, which he did. For the next few evenings, his father continued to leave matchbooks with matches around the house, which R. brought to him. The continuous reinforcement ranged from 1 to 10 cents. Matches or covers found during the day outside were saved by R. and given to his father at night. At this point in the treatment, his mother also became involved and began to reinforce him when he brought the matches to her.

Since R. was possibly striking matches he found outside the home, strengthening nonstriking behavior was included in his treatment. About a week after the program started, R.'s father told him he could strike a full packet of matches if he wanted under the father's supervision. Twenty pennies were placed next to the pack, and R. was told he would receive one penny for each match left unstruck. Likewise, 1 penny would be removed for each one lit. During the first session, he struck half the matches and earned 10 cents. The next evening he earned 17 cents, and the third evening 20. In future sessions, he decided consistently not to strike any matches. The rewards he received during these sessions varied, ranging up to 10 cents. Social reinforcers were given along with the material rewards throughout the program. By the end of the fourth week, his firesetting behavior had been eliminated. An eight month follow-up revealed no recurrence of the behavior. During these eight months, the father had continued using a variable-ratio reinforcement schedule with monetary rewards for R.

Combination of Behavior Management Techniques

McGrath, Marshall, and Prior (1979) reported a treatment program which was developed for an 11 year old boy who had repeatedly set fires. The program was designed to modify the behavior on several levels and to suppress firesetting, to teach appropriate, alternative behaviors, and to make him aware of the consequences of firesetting.

T. was next to the youngest of 7 children from a multiproblem family which had been involved with social service agencies for several years. He had been placed by the courts in a group home following several firesetting episodes. T. had set a fire in the group home and was then kept in a detention home. Subsequent to a psychiatric evaluation, four hypotheses were generated in regard to his firesetting:

1) Firesetting occurs following difficulties in coping with stress.
2) Firesetting occurs following difficulties in relating to peers in an age-appropriate manner.
3) Firesetting is reinforcing.
4) T. does not realize the danger of firesetting.

From these a treatment plan was developed. Social skills training was utilized to assist in correcting his responses to stress and develop age appropriate peer interactions. Fourteen hour-long sessions of role playing, modeling, and rehearsal were carried out. Specific situations where T. had problems were role-played. His responses were videotaped and played back. When his behavior was inappropriate, alternative responses were discussed, modeled by the therapist and then rehearsed by T. Alternative responses included covert self statements.

In order to eliminate any reinforcement he might be obtaining from firesetting itself, an aversive procedure with a strong educational component was undertaken. T. was required to gather sheets of paper, a pail of water, matches, a scrubbing brush, and a metal container. He then lit a sheet of paper in the container and extinguished it using the water. With the brush, he then scrubbed the container thoroughly.

Throughout these actions, he repeated aloud instructions about the dangers of fire and the need for safety, such as "Fires can kill people" and "This fire is safe because it can't spread and there is water to put it out" (p. 70). This sequence was repeated 3 times per session for 11 sessions.

Five sessions of covert sensitization were used to help increase the aversiveness of firesetting. In each session a different five minute audiotape was presented describing T. setting a fire. The scenes were fictitious but similar to his actual fires. In addition the possible aversive consequences of firesetting were described. Following the anxiety-inducing tape, a relief scene was presented which described T. as thinking about setting a fire, deciding not to, and finding alternative ways of coping.

The final treatment approach included fire safety instruction and the completion of a project. He visited the fire department and talked with the fire chief about the dangers of fire. For six weeks, three weekly one-hour sessions consisting of reading a book on fire safety and then answering questions were held. Also during this time he viewed films on destruction caused by fire. At the end of the instructional sessions, he presented a project on fire safety to the fire chief for his evaluation.

All four treatment components were included in a contract which was integrated into the point system used at the detention home.

The treatment program was found to be effective in increasing his ability to cope with stress appropriately and to interact appropriately with peers. During the transition phase, T. continued to increase his age-appropriate behaviors, to progress academically at school, and to set no fires. Shortly after his placement in a group home, T. set two small fires; however, both were in flameproof containers and were not considered dangerous. In the two year period following, no firesetting behavior was noted and he continued to show social, emotional and academic progress.

Family Therapy

Eisler (cited in Schaefer & Millman, 1977) described a family therapy approach for a 14 year old boy referred by the courts for firesetting. Although J. expressed regret at setting several large grass fires, he could offer no insight into his behavior.

The family history revealed that the father had lost his business five years ago and had worked out of state at various jobs for the next four years. During that time, he only visited the family occasionally. The mother worked as a secretary in the company where the father obtained employment one year prior to the treatment and moved back home. With both parents working, J. had to care for two younger siblings after school and prepare supper. At the initial interview, the mother appeared to dominate the father and son and did most of the talking. The family agreed to come twice a week for three weeks for assistance.

The family meetings in this case lasted from two to three hours and focused on three goals set by the therapists: explore communication patterns, role assignments, and unresolved crises in the family. In this family interpersonal conflicts were not openly discussed. They communicated nonverbally; for example, the father withdrawing from the home to join a variety of civic organizations, while the son set fires. A family assignment to make independent lists of their grievances toward one another seemed to break the barrier against open communication. An exploration of roles revealed confused perceptions and further lack of communication. As the sessions continued, the father began taking a much more active and assertive role in the family. J. was able to express his resentment about having to care for the siblings even though his parents didn't believe he was responsible enough to have a part-time job.

At the end of the six sessions, the family felt they were doing well, and they decided to terminate treatment. A follow-up meeting four months later indicated that the family seemed to be functioning better, with more open communication. Follow-up by telephone one year later revealed no further firesetting incidents and improved family relations.

According to Eisler, crisis-oriented family therapy is indicated when:

1. Family members value each other and seem motivated to work toward a better relationship.

2. The family members seem capable of offering one another emotional support while discussing painful conflict areas.

3. Precipitant crises in the family history are readily identifiable. (p. 312)

Another case study where family therapy was effective was presented by Doret (1973). The parents' prime concern at the time of referral to a residential treatment center was the firesetting behavior of their five year old son. Other symptomatic behaviors included: stealing, eating problems, destructive behavior, intense sibling rivalry, and enuresis. Shortly before the referral the parents had resorted to tying F. to his bed with rope and chains to control his night wandering, during which he had set six fires in the previous two weeks, wrapped clothing around the sleeping infant's neck, and smeared feces.

F.'s family history was dramatic and traumatic. His parents had severe marital difficulties ending in a partner swap when F. was two. F. lived with his natural father and stepmother but continued to visit his natural mother for extended visits. Separation had been a paramount factor in his history.

At the time of admission two family sessions were held. The anger of the family toward F. and his defensive and acting out behavior surfaced quickly. Residential placement was determined to be the treatment of choice. He was assigned a therapist for individual psychotherapy, which continued during his stay of over three years. Also, caseworkers were assigned to his latest family and his natural mother.

When admitted, F.'s main defense was direct aggression. His behaviors included lighting fires, breaking into a building during a runaway and stealing shotgun shells, and taking a boat. He exhibited marked swings from acting out to periods of withdrawal and constriction. In the early adjustment period, F. was kept with a child worker in his cottage. It was many months before F. could move toward people and many more before he could conceive of people working together and cooperating.

After he had been in treatment for about two years, there was a violent recurrence of the aggressive, acting-out behavior. At this time family therapy began. Following the three sessions there was an extreme decrease in F.'s disruptive and suicidal behavior. Psychotherapy then once again became the treatment of choice. About a year later family therapy was reinstituted on an ongoing basis for the entire family. After several months, home visits were introduced; and later F. returned home.

Other Behavioral Interventions

Lowenstein (1979) conducted an interesting research study designed to establish the effectiveness of a treatment when compared with matched controls who received an alternative treatment or no psychological treatment at all. The children were followed for several years to monitor the continuation of the firesetting behavior.

The firesetters in his sample were separated into a firesetting control group and an experimental group. The experimental group's treatment was administered in three, 45-minute sessions per week and included aversion therapy and reactive inhibition approach, as well as educational therapy/environmental manipulation/counseling. The aversion therapy included reading about some especially unpleasant reports of injuries and devastation caused by fire, seeing unpleasant pictures of injuries resulting from fires, listening to audio tapes of screams of pain while viewing a film about fire, lighting fires while being forced to sniff ammonia, and lighting matches and being forced to hold the match with eyes closed until so painful the match was dropped. The reactive inhibition approach included being forced to light many fires repeatedly until they tire and being taken to places where fires could be safely started and allowing the practice of this behavior. The educational therapy/environmental manipulation/counseling included encouraging and teaching positive, non-destructive responses to frustration, developing remedial educational programs, and discussing long-term grievances the child had and problems currently faced.

The firesetters in the control group had two regular visits per week to a psychiatrist where they received play or psychotherapy. Regular meetings were held between the child's family and the psychiatric social worker with the emphasis on eliminating the causes of frustration and conflict in the home and at school.

The nonfiresetting controls received no treatment.

The experimental treatment was found to be superior to the others. At the five year follow-up no fires had been set by this group, as compared with six fires by the firesetting control group. The experimental group also set fewer fires during treatment.

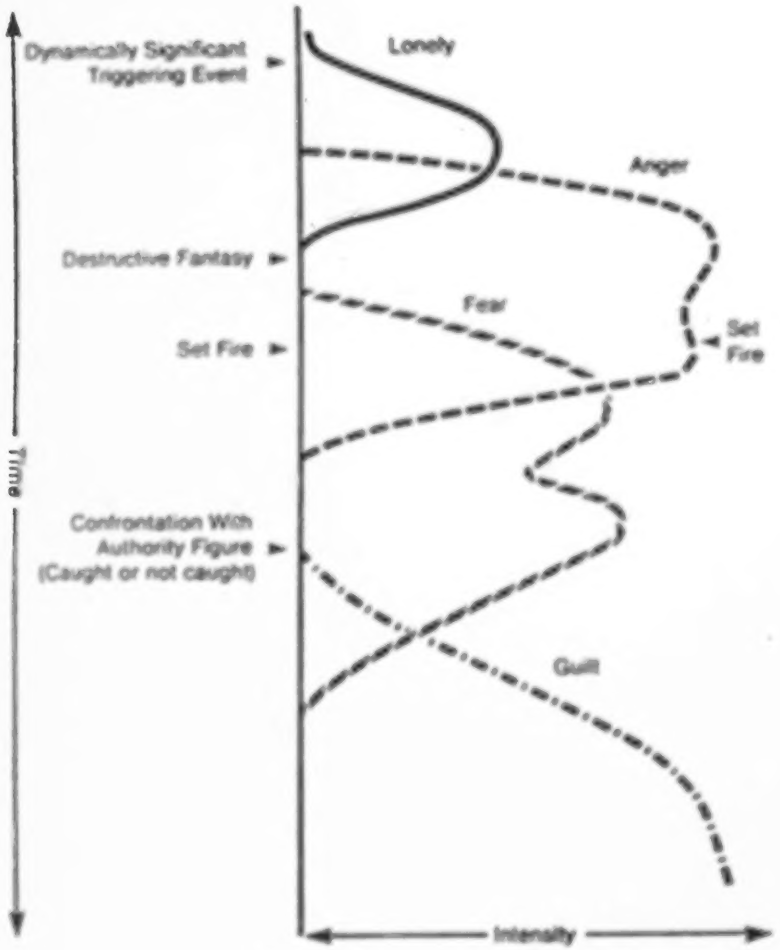
Bumpass, et al. (1983) described a treatment approach used during the initial phase of therapy that was effective in rapidly controlling firesetting behavior. The technique sequentially correlates external stress, behavior, and feelings on a line graph. The hypothesis was that the concrete visual representation of these factors aids in correlating the cause-effect relationships between feelings and behavior. The awareness then gives the child a choice between adaptive responses other than setting fires. After the firesetting behavior is interrupted, therapy reverts to a more traditional approach related to the child's specific psychopathology.

Initially in this technique, the child is told that behavior usually results from feelings and that becoming aware of these feelings, the behavior can be controlled. The graph which is developed is a concrete method of correlating described behavior, external stimuli, and feelings in a time sequence. It is constructed in the presence of the child with him/her making corrections or additions. Parents may also be present at this time. Specifically, the graph is made by listing an account of the events before and after the most recent firesetting. After this is completed, the child is asked to describe the feelings that occurred during the time period. The greater the intensity, the higher it will extend on the graph. Each feeling is individually represented.

The typical graph indicates that a sequence of events and feelings occurs in relationship to the act itself. When interpreting the material from the graph, it should be oriented so the time line is on the bottom and the sequence is from left to right. The child and his/her parents are asked what can be learned from the information on the graph. The most important factor is to become aware of the sequence: 1) a triggering event; 2) feelings; 3) resulting behavior. The cause-effect relationship is stressed. The family is then asked how the cycle might be interrupted. The child is told that the feelings in the first part of the cycle can act as a signal that he/she is at risk to act in an unacceptable manner. The awareness of these feelings allows him/her to deal more constructively with these feelings.

Since children do not set fires every time they have the urge to do so, the child is asked to list what other behaviors he/she has used in response to these feelings. These are also listed on the graph. At the conclusion of the interview, the child is told that he/she probably will not set a fire during the coming week. However, if the urge arises, they should pay close attention to the feelings and events so they may be discussed in the next interview. When no fire has been set during the previous week, the child's ability to control those feelings is strongly supported; the treatment then goes to traditional diagnostic or therapeutic interviews.

A typical graph generated may resemble:



In Bumpass et al's article this technique was utilized with 29 patients. Follow-up was completed with 26. Following the initial graphing, only four set subsequent fires. In addition to the cessation of the firesetting, most of the other acting out behavior also ceased. The data generated also indicate that understanding the cause-effect relationship and recognizing that the initial feeling can be used as a signal are the best immediate evidence of a successful treatment. Long-term prognosis is determined by the ability to correct the underlying problems. Other favorable indicators include:

"The family defining firesetting as the primary problem; the child's ability to recognize and describe specific feelings; recognition of a specific triggering event of dynamic importance; observable evidence of sadness while discussing the events prior to the anger; and evidence of a superego response to firesetting." (p. 342)

Monitoring Methods

Monitoring treatment effectiveness and subsequent firesetting behavior with children who set fires should be an integral part of their treatment plan. Much of the follow-up conducted, according to the literature, is accomplished via telephone conversations and/or correspondence through the mail. In order for the follow-up to reliably reflect the child's current status, rapport must be maintained with the family as well as the child.

McGrath, Marshall, and Prior (1979) suggest that since firesetting is a low frequency behavior, collateral behaviors related to the target behavior should be monitored. This assists in assessing the progress of the treatment and in evaluating the risk of another occurrence of target behavior.

Even though the treatments cited all reported success, Stewart and Culver (1982) state that the short term prognosis for the firesetters admitted to a psychiatry ward is only fair. No reliable method has been established to predict whether the firesetting will continue.

Conclusions and Considerations

Firesetting is very a frightening behavior in terms of potential destructiveness to property and people, reaction by the community, and lack of control once the fire is set. Many children in our society experiment or "play" with matches during the course of their development. However, in a small percentage firesetting becomes more serious.

It appears that children set fires for a variety of reasons. In the majority of cases, firesetting is not an isolated problem but rather the child exhibits several unacceptable behaviors. Firesetters do not differ significantly from other children with psychiatric problems.

The treatments in the literature all report some degree of success. It is apparent, however, that the treatment chosen for any particular child should be selected after carefully considering the parents' attitudes and circumstances, as well as the individual child. Building and maintaining the family's trust is essential regardless of the treatment plan. Close communication and cooperation between the agencies involved with the child and his/her family is imperative.

Fras (cited in Fine and Louie, 1979) suggested very directive instructions to the parents initially. If they were unsuccessful in controlling the firesetting after obtaining help, other caretakers should be considered. If the firesetting behavior is not quickly controlled, an inpatient evaluation should be obtained and subsequent residential treatment or foster home placement considered.

Some initial strides have been made in prevention of this disorder by educating school children regarding fire safety and prevention via the National Fire Protection Association's curriculum, "Learn Not to Burn". This K-8 grade curriculum is designed to teach essential fire safety and prevention behaviors that are necessary to protect one's self and others from fire, to prevent fire, and to motivate others to practice fire prevention and safety. In 1978 the curriculum was field-tested nationwide on a sample of 4,707 students. Analysis of the pre-and posted learning indicated highly significant gains made by the experimental group in fire safety knowledge and practices. (Price, 1981).

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Educational Implications of Overdependency

Lyle J. White

Abstract: This chapter explors the developmental and systemic factors that can lead to overdependency among children and provided a working definition for the term. Examples of behaviors that could be attributed to overdependency are given and relates to developmental and systemic theories. The importance of using assessment and therapeutic techniques which are sensitive to the environment or system where the overdependency was created and supported is emphasized. Implications for future research and the role of school psychology are discussed.

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Definition, Background and History

Gaining independent skills and outgrowing dependencies is part of the normal development that takes place as children becomes adults. Overdependency occurs when this process is interrupted by the social environment, primarily the family unit. Overdependency becomes problematic when a child's need for adult contact, approval, and attention is so great that it interferes with other developmental tasks such as peer relationships and environmental mastery (Sroufe, Fox, & Pancake, 1983). Children who are chronically ill, require excessive adult support and assurance in order to complete assignments, or have poor social skills could all be experiencing problems with overdependency. The foundation for this definition of overdependency rests on two different, but compatible models of behavior.

Developmental theory. In Erikson's model of development (Erikson, 1963), the failure to resolve positively the issues of trust or autonomy predicts interference with the successful mastering of the environment in the succeeding stages. The two basic precepts of this developmental model are: (a) each basic item of the psycho-social stage is related to all others and (b) each item exist in some form before its critical time. Therefore, trust becomes the foundation upon which autonomy develops; initiative then builds upon autonomy, and so on.

However, no resolution is final. Each continues to be a dynamic part of the maturational process and not a permanent achievement of an individual stage. The dependency needs of a child are both dynamic and situational. They are tied closely with earlier experiences and the basic resolutions of previous developmental stages. Having learned to distrust others, a child may find it difficult to give credibility to a teacher's compliments, risk new learning, or develop intimate relationships.

Liedloff (1977) (among others) has lived with and studied cultures markedly different from our own and has attempted to distinguish what child rearing practices have led to different adult traits. She reported that the parenting behaviors among the Yequanas Indians of Venezuela have encouraged children to set their own limits in seeking autonomy. Parents and older children give younger children only the help that they can not provide on their own. Nothing is offered that is not required whether it is nourishment, affection, or guidance. These children reportedly develop more self-reliance and in a shorter amount of time than is generally known among "civilized" children. These observations seem to support developmental theories which emphasizes the role of early experiences on subsequent behavior.

A number of other studies have attempted to determine how adult-child relationships affect children's maturation and autonomy development. Individual differences in dependency have been shown to be predictable from the early infant years, and that emotional dependency is strongly related to the quality of the infant-caregiver relationship (Stroufe et al., 1983). Children judged as having more internal focus of control were found to have mothers that provided more opportunity for cause and effect learning, and were generally warmer, more nurturant, less critical and less controlling (Gordon, Nowicki, & Wichern, 1981; Wichern & Nowicki, 1975). The adult-child relationship may also be affected by the child's behaviors. Adults may respond to children's dependencies by reinforcing already established dependent or independent behaviors (Marcus, 1975; Wyman, Schroder, & Wright, 1972).

Parent-child relationships are described in even more dynamic terms by family systems models.

Systems theories. The current practice of family therapy has a number of different orientations. Most reflect the idea of a family as a system where, like all systems, the behaviors of each individual component affects the other components and the system as a whole. Describing how a family system functions and how relationships are manifested has resulted in several models known as well by their individual adherents as by their collective names.

Salvadore Minuchin and his colleagues from Philadelphia have been responsible for much of the development of the structural approach to family therapy (M. White, 1979). In their work with psychosomatics, they (Minuchin, Rosman, & Baker, 1978) emphasize the importance of viewing patients in their social context. Therefore, a condition such as anorexia nervosa is not only definable by the behaviors of a family member, but also by the way the family interacts or is organized in order to develop and maintain the member's symptomology. Overdependancy is intimately related to the five traits given as characteristic of psychosomatic families: enmeshment (an extreme form of proximity and intensity in family interactions), rigidity in family growth and change, the inability to recognize and resolve conflicts, child involvement in parental conflict, and overprotectiveness (interactions which deteriorate the boundaries of individual autonomy and intrude on a member's thoughts and feelings). Crises occur in these families when the children arrive at a new developmental stage and the family cannot adapt to their changing needs. The result for children is the retarded development of autonomy, competence, and interests or activities outside the family.

Tiangulation is a term now used by many family theoriest (Haley 1973, 1976, 1980; M. White, 1979) to describe three member family interactions in which two members have built a covert coalition against a third. A child involved as a third member in a parental conflict is mired in a system where individuality and separation from parents are lost. In this model, autonomy is dependent on relationships (Haley, 1976). Consequently, overdependence or the lack of autonomy does not exist in an empty field; it meets the needs of the social system.

Haley, like Minuchin, contributed the upset in a family's homeostasis to its difficulty getting past a developmental stage. His term for this series of developments is the "family life cycle" (Haley, 1973). For a middle American family, the cycle is assigned six periods: courtship, marriage and its consequences; childbirth and dealing with the young; middle marriage; weaning parents from children; and retirement and old age. The second, third, and fourth stages are the most relevant to the development of overdependency.

In the second period, children are introduced into the marriage. The two member social system now becomes a triangle. Problems arise early if one parent feels the child is more attached to the other or if the child is seen as the source of new and unsolvable problems, such as one parent's loss of membership in the adult working world or a financial crisis. The most common crisis period occurs when children start school. At this point the child's increased involvement outside the family increases conflicts regarding child rearing because the couple's product is now on display. The couple also begins to face the issue of the child leaving home permanently Now they have to face each other. When one parent involves the child against the other, the involving parent becomes "overinvolved" with the child. This pattern of behavior keeps the child locked within the marriage relationship, prevents the child from maturing, and keeps the parents from developing their own lives separate from the child's.

The middle period continues the process of redefining member functions within the family. A parent who has stayed home with the children, may feel less needed as children become older and more independent. Both parents must begin to renegotiate their relationships with their children as they approach adulthood. They have to learn to deal with their children both as their children and as independent adults. For example, a mother may have evolved a pattern of behaviors in dealing with her daughter and another pattern in dealing with other adult females. If her behavior toward other adult females included treating them as competition, then she faces a dilemma as her child approaches adulthood. The father may be caught between them.

In some cultures the weaning of parents from children involves a recognized ritual or ceremony. The lack of such a demarcation leads to uncertainty and possible turmoil between the generations. For the child through whom the parents have communicated most often, the separation will be the most difficult. If the parents and child can not face separation, incapacitating social problems on the child's part can abort the separation (Haley, 1973).

The social problems that result from overdependency can assume many forms. Among these are school phobia, poor school performance, psychosomatic and chronic illnesses, and substance abuse.

School phobia. Statistically, school phobic adolescents have been shown to be immature and overdependent on their mothers for personal activities and household tasks (Berg & McGuire, 1971). These youngsters communicated less with their mothers than usual, suggesting a reduced opportunity to voice and eliminate fears. Some of these children may avoid school because it meets the family's needs by providing a distraction from a marital problem (Haley, 1973; Napier, 1978).

School success. A number of characteristics have been correlated with independent students, including: academically talented, stable family relationships, parental support, emotional stability, adjustment to reality, and comprehension and acceptance of rules and norms of society (Sokol & Marshall, 1969; White, K.A., 1982). Some of these characteristics have been associated directly with family dynamics and parenting practices. High achieving boys' mothers may have put more demands on their sons for independence and at a earlier age than did other mothers (Wyman et al., 1972). Low reading achievement in high school males has been, on the other hand, related to anger toward a parent (Dorfman, 1980).

Psychosomatic and chronic illnesses. A psychosomatic illness results from a family's interactional system (Minuchin et al., 1978). This can become a repeating cycle when parents realize that their child is approaching better health or independence and that they will now be left to face the issues which the illness had previously diverted their attention from. To maintain the family, the parents at that point have the child taken out of treatment, if it is beginning to succeed. Or, if the child is not in treatment, placed back in as a relapse case (Haley, 1973, 1980). In one group of adolescents with recurrent somatic complaints over 57% reported that the most common negative stressful event in their lives was increased arguments between parents (Greene & Thompson, 1984).

Many chronically ill adolescents have had relationships with one or both parents characterized by a withdrawal of love for independence seeking behaviors and a reward of love for dependent behaviors (Harris & Bergman, 1984). This pattern of interaction leads to a deficient sense of being able to function autonomously in the world outside the family. The youngster is kept close to the family by way of the illness. Similar relationships between parents and children often influence illness with more physical symptoms such as diabetes and asthma (Minuchin et al., 1978). This may not be true of epileptics (Meier, 1976).

Institutional dynamics such as those found on a hospital ward can contain triangulated relationships with the patient, therapist, and ward physician (Hayley, 1976). In this scenario the therapist and ward physician are at odds regarding special treatment for a patient. The therapist joins with the patient against the doctor who is seen by both as not understanding either of them. Similar dynamics could be found in a school setting. The players, in addition to a student, could include: a building administrator, a counselor, a teacher, a parent, or a school psychologist. Each has the potential to play the part of the rescuer and side against one of the other adults in order to save the student.

Substance abuse. When there is turmoil in a young person's life, few more obvious symptoms exist than substance abuse. Drug abuse may be a conviction of powerlessness and impotency (May, 1972). In adolescents, this perception could arise from an inability to meet family demands, insecurity regarding sexual ability, or failure to establish a work identity. The family of a young addict has been typified as containing both an overprotecting indulgent parent and a distant passive one (Stanton, 1977, 1979). The abusive youngster acts out of the family's belief that this is the only solution to keep the family from disintegrating. Addicts, it is suggested, may come to see themselves as the "saviors" of the family and only through their self-sacrifices, that is, martyrdom by suicide, will the family be saved.

Success with future intimate relationships and work. An overdependency history may make intimate relationships difficult (Haley, 1980; Napier, 1978). The assumption that a marriage will meet all of one's dependency needs is usually proven wrong. A couple united this way may begin to fear their dependency on each other and feel crowded and restricted by it. In the work environment, those who are relatively independent are not as likely to enter into short-term absenteeism regardless of the work environment's support or suppression of self-actualization (Omerza. 1979).

Assessment

At the center of most school psychological evaluations is a core of empirical data which is used to justify the provision of special services. This data should qualify as well as quantify the occurrence of overdependency. Questions to answer include:

1. Does the overdependency interfere with other developmental tasks?
2. Is the dependency exhibited markedly different from that associated with developmental stages or peers?
3. Does the overdependency occur generally or is it conditionally or environmentally specific?
4. If overdependency changes with the environmental conditions, are the variable dynamics time, place, or human relationships?
5. How best can the observable behaviors that suggest overdependency be measured?

There are a number of assessment techniques available for use to the school psychologist such as rating scales, self-report, projectives, behavioral measurements, and psychophysiological measurements. Because each has inherent strengths and weaknesses, a multimodality approach is most likely to provide the most useful and accurate data (Kazdin & Wilson, 1978; Kazdin, 1980). One modality can provide elaboration on another; a behavioral observation can substantiate or expand upon information from a rating scale. Different modalities can give information regarding the specificity of the behavior. For example, do the continual requests for assurance noted in an individual test situation correspond to reported observations made by teachers or parents of the child in a more natural environment?

When choosing assessment devices from each modality, the misleading characteristics of each should be kept well in mind.

Ratings by others. This information is subject to an extreme amount of bias; a correlation of r=-.20 has been reported between some observed behavior and ratings (Kazdin, 1980). The most useful devices should define the behavior specifically and clearly as well as sample a number of environmental situations.

Self-reports. This information is subject to distortion by the subjects' efforts to provide socially desirable information and by their verbal abilities. Self-reports can come from individuals or from a family interview. Techniques such as the genogram (Guerin & Pendgast, 1976) can be useful to generate discussion and diagram family interactions.

Projectives. Although there is research to support the correlation of certain responses on a projective device to behavior patterns (Ogdon, 1977), there is also evidence that suggests that these results are a function of the individual test administrator and interpreter (Kazdin, 1980).

Behavioral measures. Data from a behavioral assessment can be misleading if it was taken under contrived rather than natural conditions, did not sample a number of conditions and time intervals, did not use the most appropriate interval or frequency counting technique, did not sample behaviors that represent the psychological construct under study, did not compare the subject's behaviors with a control, or was influenced by the subject's awareness of the observer (Kazdin, 1980). The observer as well can introduce recording errors and may require training to insure reliability (Bijou, Peterson, & Ault, 1968).

Psychophysiological. This type of data gathering often requires expensive equipment not always available in the school setting. In addition it may be guilty of leading to an over simplification of relationships that exist between psychological constructs and physiological responses.

In summary, the criteria for choosing assessment devices should include: (a) multiple modalities, because behaviors are multifaceted and no one device provides a perfect reflection and (b) behaviors should be highly specified to reduce ambiguity from individual interpretation (Kazdin, 1980).

Intervention

In choosing from among the available intervention strategies or therapeutic techniques, the following questions should be considered:

1. What are the situational or systemic dimensions of the overdependency?
2. What therapy approach will most effectively promote changes within the individual and the environment?
3. Can the family be involved? If not, how can individual therapy be used to impact that system?
4. Who should be the provider of therapy, school personnel or an outside agency?
5. Is the overdependency so severe that suicide is a possibility and hospitalization is warranted?
6. What other health care or social agencies should be involved?
7. What preventative measures can be implemented through family, school, and community systems?

Therapy Choice

In choosing a therapy for overdependency, the dimensions of the system in which the overdependency occurs should be considered carefully. Some therapies may be more efficient in certain situations or for certain systems.

Acute occurrences. When an acute or isolated overdependent behavior occurs, a careful analysis of the conditions surrounding it is basic to the intervention. Although some question its ability to provide generalized behavior change, behavioral therapy has an extensive literature regarding the change of specific behaviors under controlled circumstances. For example, this intervention strategy was useful in helping a kindergarten boy overcome his fear of going to the bathroom without his teacher standing outside the door. Since no other overdependent behavior was reported by either the teacher or parents and since this behavior began immediately after he was caught alone in the bathroom during a fire drill, his overdependency was probably specific to this one situation. A systematic and gradual fading of the teacher's presence soon had the boy undertaking his bathroom activities independently.

In other cases the overdependent behaviors may be found to occur in the larger systems of family and community. Alternative forms of intervention are probably indicated then.

Family systems. Although other therapy orientations offer models for working with families (Dinkmeyer, 1981; Liberman, 1978), the family systems models provide the most detailed descriptions of and therapeutic approaches for the family as the treatment focus (Minuchin et al., 1978).

The strategic approach seeks to remove the child from a triangulated relationship with his parents (or other adults) by issuing requests to the family to interact in different ways. These requests are strategical and designed to cause a disruption in the repetitive and dysfunctional interaction patterns. Once this disruption begins, the therapy then seeks to establish more functional patterns. For example, to create a disruption, a grandmother who complains that her grandson is not handled correctly or appreciated by his mother and who also intrudes into any discipline between the two, is assigned to be totally responsible for the grandson's discipline and care for two weeks (Haley, 1976).

Structural therapy introduces change into the family system through the therapist's joining the family structure thereby creating a new structure (Minuchin et al., 1978). This is the therapist first goal since change has to come from within. By assuming the leadership position in this new system the therapist begins to challenge the family's realities and reframes the family's problems so that new thinking is required. For example, the parents' difficulty getting their anoretic daughter to eat is reframed to: the parents and the daughter are in a fight for control. The therapist must also find ways to challenge the family's enmeshment and increase the opportunity for individual autonomy and yet not challenge the family's value of "togetherness." Other family patterns such as overprotection, rigidity, and conflict avoidance and detouring are also challenged and restructured.

Working with psychosomatic families may require a combination of both the structural and strategic approaches (White, M., 1979). Basic to this procedure are the steps of: (a) accepting the families definition of the problem rather than refocusing to the marriage, (b) establishing a theme about how the family interacts to solve each other's problems and maintain the family, (c) involving the disengaged parent in helping the child take control of his pain, (d) restructuring the family relationship system by redrawing individual and subsystem boundaries, and (e) working with the parents to resolve underlying conflicts.

Therapy involving overdependent females may present additional dynamics and considerations (Lerner, 1983). Looking at female overdependency solely as a function of secondary gains, early deprivations, or irrational anxieties may be short sighted. Over dependent behavior may be serving to maintain the family system. This reframing emphasizes the adaptive aspects of female dependency and how it preserves family unity through the self-sacrifice of personal growth and autonomy. Male therapist in particular should be cautious about using the dependency posture of a woman to serve as a vehicle for therapeutic interventions. For example, giving a directive or a suggestion that implies, "this is what you should do" merely encourages another dependency, this time on the therapist. Therefore, a lasting change in the woman's behavior pattern is unlikely to occur.

Therapy without the family. There may be times that it is not possible to involve all or even part of the family in the intervention strategy. Nevertheless, the role of the family in the dynamics of overdependency should still be included in therapeutic strategies. Systems thinking can be combined with cognitive approaches to overdependency issues such as adolescent emancipation. Since cognitive therapy confronts the belief systems or premises that shape feelings and actions, the therapist needs to reflect and juxtapose the adolescent's expressed contradictory premises, such as the desire to break away from parental control and the accompanying fear of being without them (Wood, 1980). After restating the paradox, the therapist allows the adolescent's judgment regarding the statement to prevail, since forcing a point of view would likely meet with resistance. Using role playing or psychodrama would allow for the introduction of some family dynamics into the therapy, some individual restructuring regarding the family, and a chance to practice new behavior within a substitute system.

Severe and chronic overdependency. The life endangering severe and chronic problems that can arise from overdependency such as somatic illnesses like anorexia, drug and alcohol dependency, and other nonsocial behaviors should receive intervention at specialized clinics which require the participation of the whole family (Minuchin, et al., 1978; Stanton, 1979).

Community Coordination and Prevention. Coordinated and cooperative efforts among community health care professionals is essential for an effective preventative program. This is especially true for members of the educational and medical communities (Greene & Thompson, 1984). A school health team composed of physicians, nurses, school psychologists, counselors, and others would provide a more unified approach to meet the physical and psychological needs of children with chronic somatic complaints. Responsibilities of the team would include coordination of direct services and preventive programs, consultation to agencies and other health care workers, and the training of medical and educational personnel.

A coordinated community prevention plan should attempt to impact upon children through their families and through the school system. One of the more popular parent education programs available is Systematic Training for Effective Parenting (STEP) (Dinkmeyer & McKay, 1976). This program is based upon the Adlerian model of family interaction and children's goals of behavior as developed by Rudolf Dreikurs. A program specifically designed to help parents to prepare for developmental separation is also available (Phinney, Dittmann, & Huebner, 1979). This program emphasizes the importance of an early and strong attachment between parent and child as the basis for more independent behavior latter on.

School systems can and should play an important part in preventive programs because parent education and support whether offered through the spiritual or secular communities does not reach all children. The most successful preventative programs have been those which have included both teaching of social skills and helping adolescents learn to deal with peer pressure (Severson, 1984). Instructionally, particular teaching styles have not been associated with more effective learning for either dependent or nondependent students (Luckett, 1979). A good educational environment probably contains a variety of instructional styles.

Monitoring Methods

The goal of monitoring is to document behavior change that has occurred since the original base line data was drawn. To this end monitoring techniques should be consistent in setting and procedure with the original measurements. As with assessment, multiple measurements should be used when possible, because single measurement techniques and isolated data can be, and often are, misleading (Kazdin, 1980). When devising follow up assessment strategies, a number of precautions should be considered. The best monitoring is unobtrusive or nonreactive, that is, the subject is unaware of being measured and will consequently respond or act normally. Testimonials, questionnaires, inventories, and interviews all are susceptible to social pressures and influences. Observations in the natural environment or setting where the problems were indicated are preferable to a clinical setting, even when observing responses to a contrived situation. Archival records such as number of days absent from school or grades are nonreactive, but may be influenced by conditions other than those of the treatment. Follow up monitoring should be long enough removed from treatment to properly assess permanent behavior change, six months or longer in most cases.

Conclusions and Considerations

Review and Integration. The definition of childhood overdependency as dependency that inhibits the growth of other developmental tasks such as peer relationships and environmental mastery is consistent with the developmental and systems models examined in this chapter. These models contain common elements and patterns. The developmental models emphasizes how the individual is influenced by the social environment. Systems models look at the social environment as a unit, how it affects the individual members, and how they in turn affect the system. The latter seems a logical outgrowth of the former. Each is clear that the physical and social development of children necessitates change within the family system. It is when the system does not change to meet the developmental needs of individual members that a crisis or a dysfunctioning occurs. It should be noted that some research (Marcus, 1975; Wyman et al., 1972) has suggested that parenting styles are affected by a child's already established dependent or independent behaviors. These findings bring up the often discussed nature versus nurture dilemma and questions the impact of the social environment on personality development. Certainly more definitive answers must come from longitudinal studies that begin with the initial contacts between parents and infants and continue through the child's early adulthood. Nevertheless, the flexibility of the family system to meet both the needs of the individual members and that of the family seems to be the critical factor in the development of autonomy.

A family's inflexibility is manifested when a parent forces separation or contact with an infant without consideration for the infant's desires or needs. It can also be the overinvolvement or exploitation by a parent of an older child in an attempt to keep the child so enmeshed in the family that it is impossible for the child to attend to learning and social skill development. The results of such inflexibility and insensitivity to developmental needs have been associated with a number of psychological and social dysfunctions including school phobia, psychosomatic illnesses, substance abuse, work absenteeism, and difficulty as an adult with intimate relationships.

Implications for School Personnel. Because school learning is affected either directly or indirectly by overdependency, it is an important topic to the educator. Because it affects social development and future adult adjustment, it should be a concern to all society.

Teachers should be aware of the basic manifestations of overdependency for they serve as the initial contact, referral source, and part of the intervention team. They need the support and the resources necessary to teach students according to their individual needs, since no one style of teaching seems most appropriate for a general characteristic such as dependency. Most importantly they, as well as all school personnel, need to be aware of the dynamics that contribute to overdependency in a family system so that these dynamics are not repeated at school. This could occur, for example, as a lack of approval for a student's products or as a triangulation with a student against another staff member.

Psychologists in reviewing referrals and making assessments should ask diagnostic questions that will help determine if overdependency is involved. They should be keenly aware of the family's role in creating and maintaining an overdependency as well as the possibility that the school as a system is also contributing to the child's difficulties through the lack of role definitions, unclear power distributions, false assumptions, or destructive alliances (Green & Fine, 1980). Assessment and follow up strategies should be as precise and nonreactive as possible. Observations should occur in the natural settings where the problem behaviors occur. And, the influence of the family system should be considered and dealt with during intervention.

Implications for the Future. More research is needed to substantiate or disprove the available developmental and systems models. Studies such as the one by Stroufe et al. (1983) need to begin measuring and observing parent-child behaviors at birth and follow them through the childrens' emergence into adulthood. The importance of the family system in dysfunctional behavior and systems oriented therapeutic techniques need increased emphasis in the training and practice of school psychology (Green & Fine, 1980; Smith, 1978). Most importantly, school psychologists must work with parents, teachers, educational administrators, board members, and community leaders to broaden the scope of school psychology into those nontraditional areas that so markedly effect the education of children.

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Chronic Illness in Childhood and Adolescence Considerations for School Personnel

Margaret L. Potter

This article discusses chronic illness among children and adolescents in relation to the school setting. Issues relating to the impact of chronic illness on the student, parent, siblings, classmates and teachers are addressed and recommendations made for provision of services to those affected by the presence of the illness.

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Introduction

The ramifications of the occurence of a chronic illness in childhood or adolescence go far beyond treatment of the actual physical disorder. While this fact has been increasingly recognized by health professionals in regard to the adolescent's psychosocial adaptation to the disease, relatively little attention has been paid to the role of the school in such cases. Over ten years ago Cyphert (1973) lamented the lack of information on the implications of chronic illness in the school setting. Since that time there have been few articles, especially in educational literature, discussing school issues related to chronic illness. Yet, chances are that even in the smallest of schools, the school staff will need to work with a child with a chronic illness at some point. In larger schools, it is relatively common to have students with diabetes, epilepsy, asthma, or some other long-term illness.

It is difficult to estimate how many children and adolescents are affected by chronic illness. Numerous statistical studies exist, but results often vary dramatically due to differences in definition of what constitutes a handicap/illness, differences in the demographic characteristics of the populations studied, and differences in how the cases are counted (for example, counting just new cases, counting cases where a child was showing symptoms at the time of the count, or counting all children under a certain age who have ever been diagnosed as having the illness) (Ruess and Lis, 1973). Ruess and Lis (1973) have identified two primary objectives for the use of statistical rate data: a) to provide a rational basis for planning treatment services and facilities, and b) to use rate data as a component of prevention strategies. But, while statisticians may estimate that one child in 1,000 under age ten will have diabetes (Delmater, Bubb, Warren-Boulton & Fisher, 1984) or one in 3,000 will be born with cystic fibrosis, or three in 10,000 will have juvenile rheumatoid arthritis (Meyers, 1975), statistics do not mean much when one is faced with blue-eyed, blond-haired Kerry who was just diagnosed as having cancer, or fifteen-year-old Tracy who is having to deal with the social stigma of epilepsy.

For the purposes of this paper, chronic illess will be considered to be any medically managed illness whose treatment course is considered to continue over a period of years. Falling under this category would be such conditions as: cancer, diabetes, epilepsy, cystic fibrosis, asthma, cardiac disorders, juvenile rheumatoid arthritis, phenylketonuria (PKU), hemophilia, and kidney disorders. This list is by no means exhaustive and the material in this chapter should not be considered restricted to cases involving just these disorders. The material is also relevant to students with a myriad of other disorders such as those who have suffered severe burns, disfigurement, amputation, or paralysis due to accidents. In other words, the focus of this chapter will be on medically labeled disabilities which generally have an indirect rather than direct influence on school performance.

There is more variety than unity among chronic illnesses. Not only do the medical specifics of each condition vary, but circumstances also vary. For some, the illness may have been diagnosed at, or soon after, birth. For others, onset and/or diagnosis may not have occurred until the child was a preschooler, grade school student, or even an adolescent. In these cases, onset may have been gradual, as in the case of a tumor affecting motor skills, or sudden, as in the case of a grand mal seizure. Signs of the illness are readily observable in some cases, in others few outside the family may know of the illness. With proper medical control, conditions such as epilepsy, diabetes, and asthma are generally not considered to be fatal illnesses. But, while many kinds of cancer are no longer considered to be incurable (Ross, 1984; Van Eys, 1977) those children with cystic fibrosis or sickle cell anemia know that their chances of living past young adulthood are slim and those with cancer and other diseases may feel that their future is, at best, uncertain.

The school plays an important role in any child's life, for as Kirten and Liverman (1977) put it, "... school is the occupation of the child." School attendance may be especially important for the student with a chronic illness. School is a symbol of normality (Toch, 1972) and may be one of the only places where those with chronic illnesses are not viewed chiefly in terms of their illness (Eiser, 1980). In a life governed by medical rules and regimens, school may be the one place where a child or adolescent can feel some sense of control and accomplishment (Kagan-Goodheart, 1977). The school also plays a major role in social and emotional development. This aspect of a student's education is especially important in that emotional health may have a significant influence on physical health (Toch, 1972).

Unexpected long-term disability through illness or accident is not the only major stress that may be faced by a child or adolescent and its presence does not guarantee _a priori_ that there will be serious adjustment problems (Kellerman, Zeltzer, Ellenberg, Dash & Rigler, 1980; Pless & Pinkerton, 1975; Waechter, 1979). Common sense and experience, however, tell us that the vulnerability for problems is there and must be recognized. The school staff is in a unique position to help manage the non-medical aspects of chronic illness. While the general goal of the medical profession is to minimize pathology, the purpose of the school is to maximize potential. There are a variety of professionals within today's schools with knowledge and training that can be of assistance to the chronically ill student. Yet, before any assistance can be effectively provided, the school staff involved must be able to recognize the needs present, understand the situation as clearly as possible, get beyond the medical mystic that may be present, and most importantly, come to terms themselves with the emotional impact of a serious and possibly life-threatening illness.

The particular knowledge and training of the school psychologist can be valuable in dealing with the problems faced by the chronically ill student and those around him. The psychosocial issues being emphasized now by those who work with the chronically ill logically fall within the realm of the school psychologist at the school level. The school psychologist can make important contributions in terms of consultation skills, organizational and interdisciplinary coordination, interventions, (behavioral and nonbehavioral; group and individual), knowledge of normal development and, in many cases, a greater knowledge of and sense of ease with the medical community than is true of most other school staff. This is not to say that other school personnel cannot deal effectively with the chronically ill student. Each situation is different and to assume that any chronically ill student is chiefly a case for the school nurse's attention or for the school psychologist's attention can reduce the sense of responsibility that others feel in regard to making school the best possible experience for the student. That is why the rest of this chapter is not directed specifically toward the school psychologist or toward any other specific category of educational personnel.

This chapter is an effort to delineate some issues to consider when dealing with a chronically ill student. Because individual situations vary so much and because of the lack of research findings to give guidance as to what or what not to do in a given situation, the following information primarily is intended to serve as a basis for creative problem-solving. The first main section is aimed at developing an understanding of issues related to being a chronically ill student or to being a parent, sibling, classmate or teacher of a chronically ill student. The next section discusses assessment issues. The Intervention section then offers a listing of possible interventions that can be used with students, parents, siblings, classmates, and school personnel. Lastly, the Monitoring and Discussion sections address some of the general issues of serving the chronically ill student in the regular school. Each section can be read independently of the others. The reader is directed to the Table of Contents for assistance in locating areas of particular interest.

Relevant Issues and Considerations

Chronic illness not only affects the child or adolescent with the illness, but it also affects the social system surrounding that young person. This system includes family, friends, classmates, medical staff and school staff. There is an interaction effect within this system with the actions and reactions of each part affecting the other parts of the system. Specific issues related to the chronically ill student, parents, siblings, classmates and school staff will be discussed below.

The Student

A disease or injury may be a modifying factor in a person's growing-up experience, but it rarely supercedes it. A young person with a chronic disease or disability is just that--a young person with a disease or disability. One must continually beware of submerging the person in the disease/disability. As van Eys (1977) put it when discussion children with cancer:

> "The child with cancer is just that, nothing more or less. He is not a normal child who has a cancer that can be removed without any trace, nor is he a child who labors under a burden that should be constantly

lifted from him as the overwhelming focus of his care. The child should be accepted for what he is, a child with cancer, who would be a different person if the cancer suddenly did not exist or if the memory were suddenly erased." (p.165)

Since it is very easy for medical professionals to lose sight of the person in their concern over the physiological disorder, it is that much more important for the school to focus on the person behind the disability. General concensus indicates that the child with a disability should be treated as normally as possible (Cyphert, 1973; Kagen-Goodheart, 1977; van Eys, 1977). This aim for normality extends to even the terminally ill, for "... if one does not expect a cure and yet manages to achieve it, a truly cured child will not result" (van Eys, 1977). School is a part of a normal child's life and thus is a vital component of any attempt to normalize the disabled student's life. By its very nature, the school provides the child with the opportunity to be a child and the adolescent with the opportunity to be an adolescent.

The Return To School

While returning to school after a hospitalization may epitomize a longed-for return to normality, it also can be a traumatic experience fraught with uncertainty. Almost everyone can relate to the feeling of being more reluctant to go back to school or work after being gone for a week or two than after being one for just a day. One knows that it may take some time to "get back in the groove" not only in terms of re-establishing work habits, but also in regard to renewing personal relationships. One can never totally catch up on the events and activities that took place during the absence, thus there is a loss of shared experience, a loss which to a greater or lesser degree can make one an "outsider" rather than an "insider". For a student returning to school after an extended absence, especially if the absence was due to a newly diagnosed illness, the return can be especially difficult. Not only must these students rejoin the stream of school life which has been travelling on for some time without them, but because of their own experiences during that time, they may be returning as somewhat different persons physically and emotionally. They do not know how others will react to them and they do not know how they themselves will react to how others react to them. Social acceptance is a major concern of almost every child or adolescent and every time a student has to return to school after an extended absence or has to start a new school, that social acceptance is tested. There also may be the fear of academic failure, especially if school had not previously been a successful experience or if the student fears that his illness will affect his ability to keep up academically. Parents may add to the student's anxiety about returning to school. If the illness is newly diagnosed or their child has just recovered from a life-threatening episode, the parents may view their child as very fragile and vulnerable and may be anxious themselves about sending him back into unprotected environs of "the real world". (Delmater, Bubb, Warren-Boulton & Fisher, 1984; Ross, 1984).

The factors listed above may contribute to the development of school phobia. This possiblity needs to be considered if there seems to be an unusual frequency of somatic complaints and school absences (Klopovich, 1979; Lansky, Lowman, Tribhawan & Gyulay, 1975). With a student with a chronic illness, extra sensitivity and good communciation with the student's parents and/or physician may be needed to determine whether absences are indeed due to the chronic illness or whether they are related to avoidance of perceived or actual school stresses (McCollum, 1981).

Educational Needs

For the most part, chronic illnesses do not directly affect a student's cognitive abilities. However, academic progress can be negatively affected by chronic illness (Stehbens, Kisker, and Wilson, 1983). Merely the frequent absences necessitated by some medical conditions may slow a student's progress. The long-term effects of the intensive drug regimens now used in battling serious illnesses are as yet unclear, but it is known that side effects of some medications can influence attention, concentration, mood and energy.

Emotional states relating to the disease may affect academic progress. The student who is depressed because his health is not good, is anxious about an imminent hospitalization, or whose family is in turmoil likely will not be doing the best schoolwork possible. But, care must be taken not to automatically attribute all academic problems to the illness. Academic difficulties may be due to factors unrelated to the illness such as general ability or learning disabilities.

Stamina may also be an issue for the chronically ill child. Because of the affects of the illness and/or the treatment the student is receiving, the chronically ill student may not be able to move at the same pace as other students. The student may need to pay special attention to physical activities within the school. Some students may be able to tolerate intense activity over a short period of time while others may be able to handle a more moderate level of activity over a longer period of time. Advance notice and planning may be necessary in some cases so that adjustment can be made in medications to allow the fullest possible level of participation in school activities.

Developmental Issues

Developmental issues, such as social maturity, identity, dependency, defense mechanisms, sexuality, and setting of future goals, will influence how the child or adolescent deals with the chronic illness just as the illness will influence the way in which these issues are dealt with by the young person. As medical treatments have improved over the years allowing some previously terminal illnesses to become chronic illnesses and changing focuses from crisis management to long-term maintenance, interest has increased in examining the psychological concommitants of chronic illness in children and adolescents (see for example, Adams, 1979; Boyle, diSant'Agnese, Sack, Millican, Kulczyck, 1976; Isaacs & McElroy, 1980; Kumar, Powers, Allen & Haywood 1976; Tavormina, Kastner, Slater, & Watt, 1976; Waechter, 1979.)

Social maturity. Social maturity develops chiefly through interaction with others (Waechter, 1979). The school as an institution fosters the development of such socially desirable attributes as responsibility, delay of gratification, and community spirit. The worth of ideas and personal values, the meaning of emotions, and the perceptions of the behaviors and intentions of others are often tentatively explored through interactions with peers. McAndrew (1979) reports on a group of young people with spina bifida attending regular schools and special schools in Australia. Most of those attending regular schools did have some problems with peers in regard to being teased, stared at and questioned, especially in the primary and lower secondary grades. However, "the young people who attended ordinary schools commonly believed that the most important lesson they had learned there was about social relationships--'The basics of getting on with people', 'respect for others' feelings', 'what is acceptable and what is not'." (p. 622)

A major barrier to the normal development of socialization skills is isolation from peers. Many factors may inhibit the usual opportunities for peer interactions. Parental overprotection or very real limitations of the illness may keep the preschooler out of nursery school, the grade schooler out of Scouts or the adolescent out of extracurricular activities. A child with cystic fibrosis who must sleep in a mist tent may never be able to go to a slumber party. A teen on a restricted diet may feel too self-conscious to join friends when they go out to eat. D. D. Etzwiler, a pediatrician who has worked closely with many diabetic children and adolescents, once observed that Tab was the best thing that ever happened to the diabetic teenagers--for the first time they could walk into McDonald's and order just like anybody else (personal communication, May 19, 1981).

Naturally, frequent and/or extended absences from school can interfere with the usual socialization process. During these periods it may be difficult to maintain contact with classmates and neighborhood friends. Instead, it is likely that the young person is living in a very adult oriented world, either at home with mom for company during the day, or in the hospital. A hospitalized teen may not have much opportunity tc see anyone his age. Many hospitals do not have adolescent units, so the teenage patient is shuffled in either with adult patients or placed on the pediatric unit (Gemson, 1977).

Another barrier to age-appropriate social development is appearance. Physical differences due to the illness may make a student self-conscious possibly leading to a tendency to withdraw from peers. The normal desire, especially among older children and younger teens, to blend into the crowd and to avoid being different in anyway possible may also lead to peer rejection because the chronically ill student is different and is different in a way that other kids may not understand and may even fear. The illness or treatment also may make the student look much younger than he actually is which can result in both adults and peers treating him as if he were younger.

Identity. In Erik Erikson's taxonomy of developmental stages, adolescence is characterized by the struggle to establish an identity. This is a period when the youth seeks to discover who he is and to conceptualize what he will become. This task involves a search for a sameness within himself and a reflection of this constancy in others (Liebert, Poulos & Strauss, 1974). The school community plays an important role in this search for identity. The school provides an arena for experimenting with various commitments and identities and provides a vital link to the future in terms of college preparation, vocational training, and extracurricular activities. More importantly, the school community provides the peer culture which supplies models for the youth and valuable feedback in relation to the development of a set of attitudes, values, and goals.

The disabled adolescent in a regular high school generally must conduct the search for identity without relevant role models and often without those experimental experiences available to able bodied peers. For example, the chronically ill youth may not be able to participate in extracurricular activities because of irregular attendance or the physically handicapped student may not be able to take some vocationally oriented classes that he may once have considered.

The way in which the ill or injured child or adolescent is accepted by both adults and peers in school may be an important influence on the youth's developing sense of identity. For kids who have an illness which demands a large amount of attention, it may be difficult to separate themselves from their illness. They become known by their illness and much of the attention they receive is because of the illness. They are referred to as "the diabetic in Room 20" or "the hemophiliac in Ms. Smith's class". Doctors are interested in them because of their illness, and the more severe or unusual the illness, the more interested are the medical people. Extensive treatment regimens demanded by the illness or pervasive family stresses caused by the presence of the illness may make it seem at times as though the child or adolescent's main impact on the family is due to the illness not to who he is as a person. The task for the young person then becomes one of learning to view oneself not as a diabetic, but as a person with diabetes, not as a hemophiliac but as Terry Jones who likes math, hates English, is Jimmy's older brother and who happens to have a condition known as hemophilia. Getting to this point may take a lot of trial and error, testing of limits and trying-on of different roles and identities. But that is a part of normal adolescence--the process may just be complicated by the illness and by others' reactions to the person with the illness.

Dependency. Dependence/independence is an issue throughout the developmental years, from the two-year-old who says "No!" to everything to the teenager breaking curfew. Chronic illness often forces dependency even when a young person wants to and needs to exert his independence. Parents may encourage continued dependency out of a reluctance to let go. For some parents it has been their diligence, care and dedication to treatment programs that has meant the difference between life and death for their offspring. To turn the responsibility for that life over to a young person who may not be as diligent in taking care of himself as they were, can be scary. Also, increased independence is a sign of growing up and in the case of some illnesses, growing up means dying.

The child or adolescent may resist increased independence. The illness may be used to avoid responsibility and to gain attention (Waechter, 1979). Dependence may also be a means of sharing the burden of the illness. For example, McCollum (1981) cites the case of one young man who insisted that his mother set out his pills every morning--he seemed to need this gesture to reassure himself of her concern and willingness to share responsibility.

In the case of some chronically ill adolescents, the normal search for independence may result in rebellion against their illness. This may take the form of cheating on diets, "forgetting" or refusing to take medications, or engaging in forbidden activities. Or, the illness may be used as a means of exerting power--to win an argument, to gain privileges, to excuse actions. In some cases, resentfulness at the dependency forced by the illness may manifest itself not in relation to the illness itself, but in regard to the non-medical aspects of the young person's life such as school, church or family traditions and regulations.

Body Image and Sexuality. The physical hallmark of adolescence is puberty. Concommitant with the physical transformation from child to adult are cognitive and emotional changes in the perception of self. In our society, puberty is as much a social phenomenon as a physical phenomenon. A large part of coming to terms with one's own body is through comparisons with others. For most adolescents the school provides the 'normative sample' of peers with which to compare oneself. This comparison not only takes place covertly, in the general activity of the school, but also more overtly in lockeroom, lunchroom, and hallway discussions. The school curriculum influences the adolescent's changing body image through physical education and health education courses.

Depending on the age of onset and the nature of the chronic illness, the teen may have to deal with the usual body image issues compounded by the additional changes engendered by the illness. The older adolescent with a newly diagnosed illness or recent injury who has already become used to his adult body may have to make drastic alterations in that body image which has been developed (Waechter, 1979). In the case of dramatic physical changes, such as amputation, this change in body image may involve a grieving period (Kagen-Goodheart, 1977). For some teens, their illness may delay puberty and, as anyone who has contact with teenagers knows, being slow to mature physically can be traumatic for a teen. The striving to achieve what is perceived as the ideal body is important to many teens; it may be difficult for the disabled teen to discard that goal when confronted by a body that is not capable of even approaching an idealized form. Although many teens will espouse a fierce independence, there is still a strong need for peer group conformity. Few people like to be noticeably deviant from others in their social milieu. Therefore, for a teen who may be sensitive about physical appearance to begin with, a 'deviation from the norm' caused by the illness may be difficult to adjust to. Also, some of the traditional ways of affirming one's masculinity or femininity, such as participation in athletics, dating, or being able to wear the latest fashions, may not be readily available to the ill/injured adolescent because of physical, social or even financial reasons.

Another issue of concern is the fact that the physiological changes of puberty may affect the course of the illness--for better or for worse

(McCollum, 1981). A formerly routine medical treatment pattern may need to be adjusted to accomodate these changes. Some illnesses require intrusive physical examinations and/or treatments which threaten the teenager's sense of privacy and personal space. Changes in examination or treatment procedures may be in order out of respect for privacy needs.

The handicapped person often is thought of as an asexual being. This is definitely not the case; rather it is especially important to address the sexual needs of the chronically ill adolescent in terms of both educational and emotional support because of the complicating factors of the disease. Perhaps most traumatic for some chronically ill adolescents is facing the possibility or likelihood that parenting children (except through adoption) may never be advisable or even possible for them. Fertility may be affected, treatments may have affected genetic structure, pregnancy may threaten the mother's health, sexual performance may be affected, there may be the danger of passing on the illness to children, and, for some whose future is very uncertain, it must seem that the biological clock is running at triple time. Coming to terms with their sexuality may be a problem for some adolescents, for a few it may be a tool of rebellion. Sexual activity may be a means of asserting control, denying illness, and attempting to "prove the adequacy, worth and desirability of one's body" (Blos & Finch, 1974, p. 532).

Coping Mechanisms. The manner in which a person copes with chronic illness depends on a myriad of factors such as age, sex, temperment, characteristics of the disease and its treatment, reactions of others, family structure and coping style, and socio-cultural factors such as economic status, religious beliefs, cultural background and community involvement.

Coping strategies may involve the use of defense mechanisms such as denial, projection, introjection, suppression of feelings, acting-out behavior, and regression (Waechter, 1979). While maladaptive reliance on any of these defense mechanisms may lead to behavioral or academic problems, these means of defense can be very adaptive in coping with the sometimes overwhelming pressures of chronic illness. For example, Ross (1978) notes that remission in cancer patients is often characterized by a healthy denial of illness. By "healthy denial" Ross means that while the existence of the disease may be essentially denied, the patient still keeps appointments for check-ups and treatments. A pathological denial, on the other hand, would be characterized by such things as refusing treatment in the face of overt signs of illness, lack of judgment in regard to treatment, and inability to detect the worsening of one's condition. Healthy denial can help one to function even in the face of a very uncertain future (Zeltzer, Kellerman, Ellenberg, Dash & Rigler, 1980).

Children's understanding of their illness and their ability to cope with it and its limitations will change as they grow older. McCollum (1981) discusses different stages in understanding:

(Early Childhood) Children strive as actively as adults to grasp the meaning of illness by explaining its cause. In the absence of realistic knowledge about bodily processes, young children construct personal theories of causality.

> Having been guided in their behavior by parental approval and disapproval, praise and punishment, young children

commonly develop the belief that badness of thought, word, or action will be followed by a bad experience, namely a punishment. Therefore, they also reason, if a bad experience (such as illness) occurs, it is probably punishment for wrongdoing. Young children believe that they are to blame for their illness. The child's particular theory will combine what he has heard adults--especially family and doctors--say about him, what he imagines they mean, how he observes they feel about him, and what he has done or thought or wished that he believes to be wrong. A child with diabetes may imagine that he has caused his illness by sneaking too much candy. A child with kidney disease may believe that his illness, especially if there is blood in the urine, was caused by handling his penis.

Most young children also blame outside agents, such as bad weather, animals, poison, family members.... Not yet capable of logical thought, the young child may quite freely construct different and contradictory theories to explain the same illness. (pp. 67-68)

(Mid-Childhood)

... School age children have a rapidly growing capacity to think in ways adults consider reasonable or logical...

Around nine years of age, many children show a marked increase in knowledge about the structures and functions of their bodies... However, until children are about eleven or twelve years old, their ideas are based primarily on personal observation and experience. Their ideas about the abstract are still vague. Children guess, for example, that the liver, which they cannot see or feel, is "so you can live". Although they understand that the body uses food, they have little understanding of what energy actually is other than the way they feel when they are "peppy" or "energetic"....

What a child in mid-childhood can grasp about his condition is influenced by several factors: (1) his general understanding of bodily processes including information gleaned from school biology courses, misinformation gathered from playmates, tantalizing secrets glimpsed in the neighbor's copy of Playboy, (2) the family attitudes about curiosity..., (3) family attitudes about discussing his disorder..., (4) the intensity of his worry about himself (an apprehensive child can misunderstand or block out realistic information just as readily as an adult), (5) his intellectual capabilities..., and (6) the actual information given. Basically, however, the youngster can be expected to grasp only the information that is related to bodily functions he feels or observes. (pp. 113-114)

(Adolescence)

The adolescent's newly developed intellectual capabilities, especially the capacity for logical thought and abstract reasoning, may either help or hinder him in coping with his disorder. He is now capable of understanding

> complex bodily structures and processes, as well as the effects of disease. Considerable physiological information is available to him through the mass media and the high school curriculum....
>
> Knowing is a way of feeling in charge. Many an adolescent shields himself from anxiety by taking an intellectual view of his disorder. He may become absorbed in learning about its physiology, treatment and relevant scientific research. In some cases, however, the youngster's capacity to understand the disorder intellectually is well ahead of his readiness to accept it emotionally.... Therefore, it is essential to allow the teenager to set his own pace in seeking information.....
>
> Because of the adolescent's intellectual advances, his family and medical caretakers may assume that his understanding of his disorder can be entirely rational. This is rarely, if ever, the case. Even intelligent teenagers who have been carefully educated about an extended illness, such as diabetes, tend to construct personal theories about their disorder. These theories blend fact, fancy, and emotion; they reflect the youngster's life experience and image of himself and of his place in the world. Furthermore, most, if not all, teenagers blame themselves (at least in part) for their illness.... If the self-blame is intense, the illness may be interpreted as deserved punishment, and the youngster may experience feelings of unworthiness and helplessness. (pp. 147-148)

Several investigators have looked specifically at the degree to which young people, especially adolescents, are able to cope with chronic illness. Pless and Pinkerton (1975) have pointed out that the concept of "adjustment" is difficult to translate into measurable terms. In one sense "adjustment" implies normality, but normality can be defined in a number of ways (such as, absence of disease, the ideal state, or the middle range). Furthermore, Pless and Pinkerton ask whether it is appropriate to apply the same standards of adjustment to the disabled and nondisabled, and does "adjustment" apply to the global adjustment of the disabled to the world around him or just to adaptation to the limitations of the disability? In their book, they assume that adjustment and psychological problems in the chronically ill are related to, and occur subsequent to, the illness, but they do point out that this is only an assumption--one which would be difficult to prove.

Results of studies examining the coping skills and adjustment of the chronically ill vary. While some problems have been noted, the overall impression of these studies is positive--being chronically ill does not necessarily mean that one is also going to have psychological problems. Zeltzer, et. al. (1980) administered questionnaires asking about the impact of illness to 345 healthy teenagers and 168 teens with chronic illnesses. Both the healthy and the chronically ill students noted some disruption due to illness. The authors hypothesize that relatively little difference was found between the two groups because to a healthy adolescent even a minor illness can seem very disruptive while to an adolescent who has dealt with the stresses of chronic illness over a long period of time, only a major illness seems to be disruptive. In fact, healthy adolescents reported a greater perception of disruption of popularity and peer activities due to illness than did the chronically ill--possibly because the chronically ill teen has learned to develop coping alternatives (such as developing a hospital peer group or making arrangements for friends to visit at home). Those chronically ill teens reporting a greater degree of disruption due to illness were generally those whose illness was more severe, more visible and with a more uncertain prognosis. For both groups, ill and healthy, those reporting high impact of illness were more likely also to express lower levels of self-esteem and higher levels of anxiety. Zeltzer, et al conclude that, in general, their data reflect good resiliency and coping skills in chronically ill adolescents and the data supports the idea that the chronically ill are a psychologically healthy population. This conclusion was supported further by a concurrent study by the same authors (Kellerman, et al 1980) using measures of anxiety, self-esteem and locus of control. In this study, differences were found between the ill and healthy teens only in regard to locus of control. This difference was specific to some of the ill groups (those in the oncology, renal, rheumatology and cardiology group showed more external locus of control than the healthy adolescents; there was no difference between the locus of control ratings of the diabetic and cystic fibrosis groups and the healthy teens). Kumar, Powars, Allen and Haywood (1976) compared a group of 29 adolescents with sickle cell anemia to a peer group of 26 healthy black children using Sarason's general anxiety scale, the Piers-Harris Self Concept Scale and the California Test of Personality. No differences were found between the groups on personal, social and total adjustment scales, but the sickle cell group did score lower on self concept and, paradoxically, lower on anxiety. Results of a study done with teenage girls at a camp for diabetics (Sullivan, 1979) suggests that that group of subjects was relatively well adjusted, attitude toward diabetes is important to consider in overall life adjustment, diabetes may serve as a scapegoat for other normal adolescent concerns, and depression in adolescents with diabetes may be covertly expressed through concerns about diabetes and its management.

Tavormina, Kastner, Slater & Watt (1976) administered a battery of standardized personality tests to 144 children with chronic illensses and their families. Normalcy rather than deviance characterized results across all scales. Although there were some exceptions, the authors concluded that the functional strengths and coping abilities outweighed any weaknesses.

In contrast to these results were the results of a study done by Boyle, diSant'Agnese, Sack, Millican and Kulczycki (1976) with adolescents and young adults with cystic fibrosis. Although the majority of the subjects were quite competently handling all the daily tasks of living at school or work and at home, the study interviews and psychological tests (intelligence and projective personality tests) indicated impairment of adjustment especially in relation to anxiety and depression. The authors hypothesize four main sources of stress: a) altered physical appearance, b) strained interpersonal relationships, c) conflicts in upbringing, and d) increased awareness of the future. They also conclude that IQ and coping ability were not related. The subjects in this study included a number of young adults. Pless and Pinkerton (1975) point out that studies of young adults with chronic illness are relatively rare, especially studies which include illnesses like cystic fibrosis where only in recent years have there been young adults with the illness. Because of this paucity of studies, little is know about the long-term adjustment of those with various childhood chronic illnesses. They conclude from the studies they reviewed that while there may be cases where children with severely disabling disorders can function very well as adults, there are many other cases where failure to cope and adapt successfully in childhood carries over to adulthood.

Eldon Siemers, a vocational rehabilitation counselor (personal communication, July 24, 1984) commented that in some cases a person's attitude may be much more handicapping than their actual physical disabilities. Some of these people, he said, seem to feel that society "owes them"--that they should not be expected to do much because, after all, they are sick. Others almost seem to be afraid of success. Many of these less adaptive attitudes seem to him to be related to the family's reactions to the illness/handicap.

Planning for the future. The onset of a chronic illness or a physical handicap may mean the dashing of previously held hopes and dreams. Not only may the physical condition demand a revamping of realistic expectations for the future, but there may be a large measure of uncertainty involved (van Eys, 1977). For example, cancer may involve a series of relapses and remissions, and for those diseases that now are considered inevitably terminal there is still always that chance of a cure or at least a temporary reprieve. The older child may have developed career and life goals that now have become unreasonable or even impossible (van Eys, 1977). Even the child who has grown up with a chronic illness, as he reaches adolescence begins to think more seriously about who he is and what he will become. These considerations take on greater importance as the teenager comes to better understand his disease and its physical and societal limitations.

Concerns about future plans may involve one's hopes to live independently, parent and raise children, and to pursue favorite leisure time activities, as well as to be able to hold a job and be financially independent. While the high school serves as a major source of career guidance for many adolescents, few high school counselors are likely to have much experience or training in advising the teens with chronic illnesses, yet this may be one of the groups with the greatest need for sensitive yet creative guidance.

The Family

McAndrew (1979) asserts that, "The young person's ability to cope with physical and emotional situations ultimately is not determined by the severity of the disability, but is a product of all of the environmental support systems that have been available to him since birth" (p. 628) In many ways, chronic illness in a young person belongs not just to that person, but the the entire family. Until the child is old enough to take on the responsibility of his own health care, that responsibility rests with parents and/or other older family members. The demands of the disease in terms of time, emotional and financial commitments may become the central focus of family life on a sporadic or continuous basis. Most importantly, the reaction of the family to the child and his illness will be a major influence on the child's own perception of himself and his illness. If the child feels accepted by his family he can withstand the adverse reactions of others (Ross, 1978). "In terms of psychological issues, the patient is the family, not only the sick child" (Sourkes, 1977, p. 66).

Parents

> "Grief is concerned with loss--loss that has already occurred, loss that is imminently expected and loss that is feared in the future. When a child develops a threatening illness, grief is inevitable for those who care about him. A parent grieves not only for the feared loss of the child, but also for the loss of certain hopes and dreams for him... Some hopes will need to be modified, some must be given up altogether. And so there is grief in the beginning of the illness and grief again at later times when the parents are faced with changing aspects of the child's condition. (McCollum, 1981, p. 3-4)

The stages of adjustment that parents of a chronically ill child go through have been compared to the stages in the grief process as outlined by Elizabeth Kubler-Ross and others (Capell & Bensman, 1979). Elbert (1982) summarizes these stages as: shock and denial, anger and rage, disorganization and despair, and finally acceptance and hope. Another way of looking at the stages of adjustment is proposed by McCollum and Gibson (1970). Their proposed structure is more dependent on the chronology of chronic illness and includes four stages: prediagnostic, confrontational, long-term adaptive, and terminal. These stages were identified on the basis of information obtained from parents of sixty-five children with cystic fibrosis. The prediagnostic stage covered the period between the point at which the parents first began to be concerned about the child's health and the point at which the correct diagnosis was finally made. For this set of parents, the mean length of time for this stage was about a year and one-half. The confrontational stage included the period of acute stress when the diagnosis was finally confirmed, stresses related to having to face all of the realities and implications of the disease. The long-term adaptation stage was the period after the initial stresses associated with diagnosis had passed. This was the stage of day-to-day living and coping with the disease, a period where denial as a useful defense was often interrupted by intrusions of the disease. The terminal stage was the period during which the inevitability of death and the aftermath of death had to be faced. These stages were proposed on the basis of the reports of parents of children with cystic fibrosis. However, Ross (1978) proposed a very similar set of stages of adaptation in relation to families of children with cancer. These stages were: 1) before diagnosis, 2) the diagnostic period, 3) remission, 4) relapse, and 5) death and mourning.

Within the adaptational process, a variety of emotional reactions are common. The initial reaction to a diagnosis of serious illness is generally one of shock. Because of this state of shock, the parents may be able to remember little or nothing of what the doctor has told them (Capell & Bensman, 1979; McCollum 1981, McCollum & Gibson, 1970). There may be disbelief--disbelief that this doctor's diagnosis is right while so many other doctors were wrong, disbelief that this could be happening to them and their child (McCollum & Gibson, 1970). Grief may occur not only at the point of diagnosis and at the time of death, if the child does die, but intermittently throughout the course of the illness. It may crop up unexpectedly especially at points of change in a child's life when limitations of the disease are emphasized anew, or for children with life-threatening illnesses, parents may have to go through and then pull back from a period of preparatory mourning each time the child goes through a bad period medically. In fact, for families of children with cancer, the period during relapse may be even more stressful than the original diagnosis; it may be during remission that the parents temporarily fall apart because it is "safer" then to let all the fears and anxieties show (Ross, 1978).

Guilt is another common reaction. Parents feel a responsibility to keep their children safe. When something happens to a child, parents often feel as though they were at fault--it was something they did or did not do that caused the child's ill health (McCollum, 1981; Sourkes, 1977). When the illness has a genetic basis, this feeling of guilt may be especially extreme, particularly when the genetic trait was known about in advance, but the parents decided to take a chance on having a healthy baby (McCollum, 1981). Parents also may feel guilty about resenting the disruptions the illness has caused in their lives (Sourkes, 1977) or guilt at the natural feelings of impatience and annoyance that parents occasionally have when dealing with their children (McCollum, 1981).

Anger may be directed at the hospital, the doctor, the spouse, at oneself, or at one's God (Capell & Bensman, 1979; McCollum, 1981). Anger often is the result of a feeling of helplessness, of not being able to fight this thing that is endangering their child, of not being able to control the events that are now controlling their lives. While anger may be used as a means of defense--an emotional reaction to an overwhelming situation-- it should not be dismissed lightly. Often parents do have something concrete to be angry about; mistakes are made and parents have a right to expect that serious efforts will be made to rectify those mistakes when possible (Capell & Bensman, 1979).

Anxiety may be reflected by parents in their concern about whether their reactions to their child's illness are "normal". They may be deeply concerned about whether they will be able to emotionally, physically, and financially handle all of the demands of the illness (McCollum, 1981). Most parents have had no previous experience or first hand knowledge of what it is like to deal with a chronic illness (Gliedman & Roth, 1980). The usual sources of childrearing advice--parents, neighbors, "baby books"--may not be able to help with the particular problems they face, leaving them with feelings of isolation and frustration.

As with the ill child himself, denial can be very adaptive. As long as denial does not lead to irrational decisions or abandonment of necessary treatments, it can help the parents avoid being overwhelmed by the disease. Generally it is agreed that chronically ill children should be treated as normally as possible, healthy denial can make this possible. It also allows room for hope even in cases that appear to be inevitably terminal. For, "If one fails one can adjust, but if one does not expect a cure, and yet manages to achieve it, a truly cured child will not result" (van Eys, 1977).

It must be recognized also, that the chronic illness of a child often is not the only stress with which the family must deal. Kalnins, Churchill and Terry (1980) studied 45 families of leukemic children over a 20-month period. They found that aside from the leukemia most of the families had to deal with one or more of the following situations: a) major medical complications of the leukemic child (such as chicken pox, pneumonia, etc.), b) death of another leukemic child, family member, or friend, c) illness requiring hospitalization or regular medical care in a family member other than the leukemic child, d) occupational changes, e) financial problems, and f) other changes such as moving or changes in vacation plans.

As medical technology has advanced and social sciences have developed, increasing attention has been paid to the influence of a child's handicap on the dynamics of the family. Health care professionals and educators alike are increasingly urged to attend to the needs of the family and to recognize the contribution of the family to the child's or adolescent's development and adjustment (Adams, 1979; Bergman, 1978; Gliedman & Roth, 1980; Seligman, 1979). While it is perhaps easier for the professional not to make a concerted effort to involve parents, legally and ethically this is no longer the option it may once have seemed to be. Some in the field, such as Gliedman and Roth (1980), have seen the role of the professional as one of being a consultant to the parent; others, such as Seligman (1979), have taken the view that professionals (specifically teachers in this case) and parents are coworkers, each with a valuable contribution to make toward improving the handicapped child's status.

Unfortunately, while good cooperation and communication between school and parent may greatly benefit the disabled student there are many barriers to such cooperation and communication. Not the least of these barriers is a mutual discomfort. Teachers often feel uncomfortable working with parents, particularly parents of a handicapped child, and parents often are uncomfortable about talking to school personnel (Seligman, 1979). Contributing to this discomfort on the part of school staff may be lack of knowledge of the demands of the disability and its influence on family dynamics, lack of previous experience with situations of this type, uncertainty as to the role and the capabilities of the school in regard to any necessary adaptations required by the student, as well as personal discomfort related to dealing with physical disability. Parents may view the school as an authority figure; this perception may be manifested in defensiveness, aggressiveness, or passivity. The perception of the situation and the values of the school and parent may be discrepant. The parents are apt to place the welfare of their child above the welfare of the group whereas the school is likely to be more concerned with the welfare of the group than the individual (Seligman, 1980). Also, perceptions of responsibility may differ. For example, the school may believe the parent should be actively involved in the child's education whereas the parent may see education as solely the responsibility of the school, or vice-versa.

Siblings

It is easy for siblings to become the forgotten partners in the family's dealings with chronic illness. Attention generally focuses on the ill child/adolescent and the parent most responsible for the care of that child/adolescent (usually the mother). Yet chronic illness is a major disruptive force within the family often drastically altering roles, expectations and lifestyle. Siblings are very much a part of this situation, affecting it and being affected by it. Sibling relationships may vary widely, but they are generally relationships which last a lifetime and which are very special. The siblings of a chronically ill person thus have a definite stake in what is going on, but their ability to cope may be affected by a multitude of factors such as age, maturity, ability to comprehend the situation, their own place and adjustment within the family, and the honesty and appropriateness with which the parents communicate with them about the illness and its ramifications (Craft, 1979).

The roles and reactions of siblings of chronically ill children is a topic which has received relatively little attention from researchers (Crain, Susman & Weil, 1966; LaVigne & Ryan, 1979; McKeever, 1983). Drawing conclusions from the studies that have been done is complicated by the fact of the varying research questions, methodologies, subject pools and types of illnesses involved. McKeever (1983), however, has put together a comprehensive review of research relating to siblings of chronically ill children. Although she could draw few firm conclusions from these studies for the reasons listed above, a number of points for consideration were brought up. First of all, siblings of chronically ill children are at risk for emotional and behavioral problems that they might not otherwise experience. Siblings often are uninformed about the chronic illness because parents feel uncomfortable or unable to talk about the illness with the sibling. This may be because the sibling serves a role as a "public informer" therefore information given to him is controlled to control what is known outside the family. The sibling may not want to ask for information to spare the parents the pain of having to talk about the situation. Also, the timing of the availability of information and the child's ability to understand that information do not always match (for example, by the time Joey is old enough to be able to understand why his older brother must have insulin shots every day, the treatment may have become so routine that no one thinks to explain it). This lack of information, communication, and understanding can contribute to reactions in siblings such as anger, resentment, behavioral problems to gain attention (Capell & Bensman, 1979) feelings of guilt and self-blame, feelings of isolation, and fear of being similarly affected (McCollum, 1981). McKeever identifies a number of factors which have been suggested as affecting the response of siblings to chronic illness. These include: size of sibship, ordinal position, age and sex of the healthy child, socioeconomic level, and disease characteristics. Study results cited suggest that in some cases larger families do better because responsibility is more spread out, ordinal position roles may be switched so that the ill child takes the role as the youngest, and much of the burden of being a sibling of a handicapped person falls to the female sibling(s), although boys may show more behavioral problems especially among younger children. One study (LaVigne & Ryan, 1979) indicates that manifestations of stress may more frequently be seen as withdrawn and irritable behavior amoung preschoolers while older children are more likely to act out socially. Findings in relation to socioeconomic status and disease characteristics were quite variable and complex with no clear conclusions able to be drawn other than the fact that these factors did seem to influence adjustment. McKeever concludes by urging that siblings be helped to develop their own identities and to understand the similarities and differences between themselves and their ill brother or sister, that they be provided realistic, age-appropriate information about the illness and its treatment and that they be kept updated, and that the needs and adjustment of siblings be an active consideration to parents and professionals when making decisions related to the illness.

As with the chronically ill child himself, stresses associated with chronic illness can affect the sibling's ability to concentrate and perform optimally in school. The sibling also often is on the front line in dealing with the reactions to, and questions about, his brother or sister. Sacrifices may be required of him that are not required of others his age (babysitting, not being able to participate in extracurricular activities because he is needed at home, lack of family financial resources, reduced attention from parents, etc.).

With the majority of the family's energies focused on the disabled member, the sibling may feel ignored or taken advantage of. Just the simple fact that a change has been forced on him and life can never again be the same as it was, can be very upsetting, especially to younger children. The sibling may have many questions that need to be asked or fears that should be voiced, yet the child may not feel he can share these questions or fears with his parents. If the illness is something which family members are discouraged from mentioning outside the family, the sibling may not feel as though he is allowed to mention the illness to friends much less discuss some of its more negative impacts and implications.

Classmates

Acceptance by peers may be a key factor in the adjustment of the chronically ill child or adolescent. Often when the disabled student is not truly socially integrated blame implicitly is laid at the doorstep of his peers. Yet, how can we expect adolescents to know how to act around a disabled peer when adults with much more experience in interpersonal relationships often feel uncomfortable and unsure around handicapped people?

Having a close friend who is faced with a debilitating or even potentially terminal disease or a permanent disability due to injury may be almost as traumatic as actually having the disability. Suddenly, perceptions of life and death and plans for the future may be thrown into confusion. Teachers and other adults need to be open to the questions of peers and sensitive to their search for answers. There is also the danger of underestimating the understanding and coping abilities of the child or teen--care must be taken not to gloss over the truth ostensibly to 'protect' the young person when the adult really wants to spare his own feelings (Cyphert, 1973).

In some cases, peers may automatically rally around their disabled friend; in other cases modeling of acceptance and encouragement of active support may be necessary. Nor should friendship systems be expected to remain the same both before and after the illness/injury. Friendships wax and wane as interests and people change; the young person may need help in sorting out a relationship that continues out of a sense of duty from one that is based on mutual interests and commararderie.

The School Staff

When a teacher learns of a serious illness or a disabling injury in a student, he may go through much the same process as a parent, that is, shock, disbelief, anger and grief (Cahners, 1979; Issacs & McElroy, 1980; Martin, 1974). As a significant person in the student's life, the teacher's ability to cope with this new and unknown situation may, through verbal and nonverbal communication, have an important effect on the student's self-esteem and ability to cope. Yet, their need to know about and understand the situation often is overlooked.

The teacher's reactions to illness in relation to the teacher's own mental health should not be ignored. Potentially terminal illnesses or severe permanent injury may induce the teacher to start questioning the value of his own life or may trigger the perception of symptoms of the disease in himself or in loved ones (Cyphert, 1973). It is generally agreed that in order for the teacher to work successfully with a chronically ill student, especially one with a potentially terminal illness, the teacher must come to terms with his own person feelings in relation to the disease and its consequences (Cahners, 1979; Kirten & Liverman, 1977; Martin, 1974). A good example is given by Cyphert (1973) in relation to the child with potentially terminal cancer:

> Persons, especially children, who are facing death have a fear of being deserted. Yet, the behavior of most of us who are teachers is in the direction of isolating the cancerous child. We don't know what to say to him so we say little. We fear that we might be asked an uncomfortable question, so we don't permit the opportunity for questions. We over-empathize because we identify the child with cancer with our own loved ones. (p. 215-216)

The importance of the teacher's attitude toward the illness/disability of a student has received relatively little attention, and, with only a very few exceptions (such as Delmater, et al, 1984; Dreisback, Ballard, Russo & Schain, 1982; Scandary, 1982; Schroeder, Teplin, & Schroeder, 1982), what has appeared on this subject has been in medical journals. School nursing journals have addressed the issue to some extent, but a study done by Chaston (1983) suggests that even school nurses often feel unprepared to deal with a disabled student. In that study, only 41 percent of the school nurses surveyed felt that they were somewhat prepared or well prepared to provide services to orthopedically impaired students. Martin (1974) found that the high school teachers in her study had very little accurate knowledge about epilepsy even though they were quite likely to have taught an epileptic student. A major component of being able to cope with chronic illness is having a sense of control and an important part of a sense of control is knowledge of what one is dealing with. Full knowledge and understanding of the situation is often what school staff lack. This can lead to withdrawal, anxiety, solicitude, and even hostility at having to deal with a student with special needs (Isaacs & McElroy, 1980).

In high school, not only is the adolescent perhaps more perceptive of teachers' attitudes than the younger child, but the very nature of the structure of the high school complicates the provision of support services to the school staff. The student has perhaps five or six teachers a day and these teachers may change every quarter or trimester. In any school, there is also a host of other people who may be involved, such as coaches, activity advisors, counselors, administrators, secretaries, cooks, librarians, the school nurse, special education personnel and the school psychologist. It is important that all of these people be able to accept and work effectively with the chronically ill student.

School is often perceived by the chronically ill student to be a haven of normality and the teacher is a symbol of that normality. By their actions, teachers often will determine how other students will react to a student with medical problems and limitations. Thus the teacher may be influential in determining how well the student copes with the limitations of the illness as well as how well other people cope with it. School staff with their knowledge of normal children and adolescents can be invaluable resources to parents who may no longer have a good sense of what is "normal".

Assessment

There are two different aspects to be considered in assessment and diagnosis in regard to chronic illness in childhood and adolescence. School personnel may be involved both in the diagnosis of the illness itself and in the assessment of adjustment as the chronically ill student deals with the pressures of day-to-day life.

Assessment and Diagnosis of Illness. A major portion of a young person's life is spent in school. School personnel are involved with students on an ongoing basis in situations where students are required to perform and produce under a variety of conditions. Because of this and because of the ample opportunities to compare the progress of the student with that of other students, it may well be that it is a teacher that first notices that something is not quite right.

If a teacher fails to detect medical problems, they may go undetected for a long time because no one else has quite the same opportunity to observe children over a long period of time (Valletutti, 1975). Such things as fatigue, shortness of breath, very poor fine or gross motor coordination, inability to concentrate, episodes of "blankness" or "spacing out", general malaise, injuries that do not heal, minor illnesses that seem to hang on for much longer than usual, frequent headaches, stomach aches or other somatic complaints are indications that further investigation may be warranted. Any time a student is having difficulties in school academically, physically, or behaviorally, the role of any possible medical factors should be kept in mind. It may be that the student's parents are unaware of the problem, or they do not realize that it is unusual for a child of that age. They may realize that something is wrong, but they either do not want to admit this to themselves or they are afraid that they will be thought foolish for voicing their fears.

School staff can play several important roles at this point. The teacher should compare notes with the student's parents to determine if there is an explanation for the observed problems and to find out if the parents have observed the same things at home as have been seen in school. Teachers can talk with support staff available in the school such as the physical education teacher, school nurse, principal, counselor, school psychologist, speech and language clinician, special education consultant, school social worker, or occupational or physical therapist. These people can help in deciding whether a further medical evaluation is warranted and can help to clarify the problem and the conditions under which it is observed. Interventions aimed at ameliorating the problem may be tried and their effects carefully noted. Historical data from school records may be reviewed and former teachers interviewed. Evaluations of general ability and academic skills may be useful. If a medical problem is found, all of this information may serve as useful baseline data for assessment of later school progress.

Along with being able to collect and interpret a variety of data useful in determining whether a medical referral is appropriate, school staff can serve as a liaison between parents and the medical community. They can prompt a medical referral, assist in arranging contacts with appropriate personnel, and take steps to make sure medical care is obtained if parents are reluctant or negligent in doing so. Sometimes the parents may take the child to the family physician but, for any one of a number of reasons (such as poor knowledge of normal child development, lack of opportunity to observe the referral problem, or even lack of willingness to admit that he cannot adequately diagnose the problem, or to admit that the child may in fact be suffering from a potentially life-threatening disease), the physician may downplay the problem or even deny that there is a problem. The school staff, then, may play an important role in encouraging parents to seek a second opinion or more specialized care.

For preschoolers, the special education team which is asked to evaluate a child may be the first contact the family has had with human service professionals other than the physician who provided the usual baby care. Normal baby care often consists of specific treatments for specific complaints (ear infections, childhood illnesses, minor injuries, etc.). Other concerns often are not dealt with unless brought up by the parents. Even if parents are concerned about the development of their child they may not feel that they should bother their busy doctor with vague concerns. If they are first-time parents, they may not have a good sense of what is normal behavior for an infant, toddler, or preschooler and may rationalize that theirs is just a "difficult" baby or a "late bloomer". In these cases, educators involved with preschoolers can help sort out abnormal development from normal variations in development. They can help clarify and specify a parent's concerns and identify clear questions that the parents can take to their physician. With their training and experience, educational personnel may recognize symptoms of a certain illness or type of illness which can further guide the efficient search for appropriate medical care. The developmental information obtained through the evaluations of such school-based personnel as the school psychologist, audiologist, speech and language clinician and occupational or physical therapist can be a valuable adjunct to a medical evaluation.

Moreover, in most cases these "educational" services are free to parents and are of comparable quality to similar services provided in medical settings.

During the prediagnostic stage and at the time immediately after diagnosis, school personnel can provide valuable emotional support services to parents. Parents and students are often more familiar with and more comfortable with school personnel than with medical people. Parents, and the student, may feel freer to ask questions and express concerns in the school setting. Often these questions and concerns can be dealt with by support staff within the school and even when they cannot, the school people can serve as an intermediary between parents and medical personnel. School staff can also help identify community support services which can be especially important in rural areas where the student's primary medical providers may be located some distance away and thus are unfamiliar with the student's home community.

Assessment of adjustment. It seems logical that with the inherant stresses of a long-term, possibly life-threatening illness the chronically ill student is at risk for psychological and general adjustment problems. This may well be the case, however, the concept of adjustment is something which is very hard to define and even more difficult to assess (Pless and Pinkerton, 1975). A key question is whether the same standards of "adjustment" apply to ill or disabled persons or whether behavior that may be considered "less adaptive" in a healthy student is actually adaptive for a student who must deal with a chronic illness. For example, as mentioned earlier, denial may be a very useful and healthy means of coping with illness at some points. Likewise, a certain degree of dependency may be a necessary result of the demands of the illness.

Concepts like "adjustment" are often defined, in a practical sense, by a person's performance on some objective or subjective measure of adjustment. Pless and Pinkerton (1975) have done what is perhaps the most thorough review of the assessment of adjustment in chronically ill children. They identified two broad categories of assessment--indirect and direct. They considered indirect "measures" to be not measures per se, but rather rough indices of adjustment such as receipt of psychiatric treatment, academic under-achievement, delinquency, truancy, or extreme social isolation. Direct measures, on the other hand, are those that can be administered at will. The direct measures Pless and Pinkerton discussed are those actually reported to be used with chronically ill children. These measures, objective, subjective, and projective, are essentially those commonly used in personality assessment.

Pless and Pinkerton conclude their discussion of techniques of assessing adjustment with comments on the validity of the use of objective versus subjective and projective measures:

> In one respect, behavior, whether observed by parents, teachers or an independent evaluator, may be regarded as the most pertinent form of such assessment. It could be argued, on that score, that so long as a child continues to perform well in everyday tasks, relates well to others and displays no overt manifestations of deviant behavior, it matters little what he 'scores' on psychological tests or what fantasies

> he projects in response to various stimuli. On the other hand, since overtly disturbed behavior represents already established or even advanced maladjustment, it is clearly important to identify deviance at an earlier stage if possible, both for therapeutic and investigative purposes. (p. 58)

Pless and Pinkerton point out that many of the instruments mentioned in the studies they reviewed are of somewhat questionable technical adequacy. Another issue to be considered is that of using these measures (which were generally not developed with a handicapped population in mind) with chronically ill students. An example of how this factor may influence a student's "adjustment scores" would be in the case of a measure which had a scale measuring somatic complaints. For a student with a severe long-term illness one might expect an unusually high score in this area and a low score would bear investigation. On projective measures should one be concerned about repeated references to death in the response of a teenager with a terminal illness--would lack of mention of death themes be an indication of the adaptive or the maladaptive presence of denial? It seems that perhaps the best use of these measures of adjustment is not in a normative manner. Rather, they can be used as a means of gathering qualitative data--pieces of information which can be used in conjunction with other available information to aid in the development of interventions aimed at improving the student's coping skills and addressing present problems.

While Pless and Pinkerton reviewed the use of existing devices with chronically ill children, it should be mentioned that at least one investigator (Sullivan, 1979a; 1979b) developed an instrument specifically designed to measure the adjustment of a chronically ill population--in this case diabetic adolescent females. While Sullivan feels that this instrument, the Sullivan Diabetes Adjustment Scale , can be useful in identifying self-esteem and depression problems among diabetic teenage girls, she is careful to caution against using it with a different population. This is a problem with any instrument that would be developed with chronically ill children or adolescents specifically in mind. There is so much variation among the chronic illness and the young people who have them, it would be difficult to develop an instrument which would be equally valid with a number of different illnesses and situations.

Intervention

When a child or adolescent has a chronic illness, the main goal of intervention on the part of school personnel is to facilitate coping with the illness, its demands and its limitations. Because the illness impacts many people other than the ill student himself, interventions must address not only the needs of the student, but also the needs of these other people both for the student's sake and for their own sake.

Direct intervention with the student, school staff, peers or family may be called for in some instances, while in other cases an informal monitoring of the situation may be all that is necessary. In any case, there should be one person within the school who is aware of the situation, sensitive to any problems that may arise and capable of either providing any necessary services or coordinating their provision by others. Depending on the personnel in the school, this contact person might be a school nurse, a social worker, a guidance counselor, a school psychologist, or an interested teacher. Ideally, this person would be involved from the very beginning, maintaining contact with the student, family and physician even during hospitalization to help insure the best possible transition back to school.

A close partnership between the school and the student's health care professionals can only be of benefit to all involved. Each group of professionals has unique contributions to make to the other without which neither can be totally effective in serving the disabled student. Often, hospital workers have little experience in dealing with normal children and adolescents; this is something school personnel deal with day in and day out. Conversely, schools have little experience with chronic illness or permanent injury--something medical professionals are trained to deal with. Those in charge of medical care often only met the child or adolescent after the onset of the illness or occurrence of the injury, thus they lack a good baseline with which to judge the young person's adaptation to the illness/injury. The school staff not only knew the student before the illness/injury in many cases, but can monitor the student after discharge from the hospital. With consultative help from the health care professionals familiar with the specific disease or injury involved, the school can provide an extensive, readily available and free network of support services to the student and his family. This can include services from social workers, psychologists, counselors, special educators, adaptive physical education teachers, vocational education people, nurses, speech clinicians, physical and occupation therapists, along with all of the teachers in the various disciplines represented in the typical school. Support services such as these and the degree to which the adolescent is re-integrated into the social milieu of the school may be a major influence on the ultimate effectiveness of any medical treatment.

Relatively little has been published in regard to the effectiveness of specific interventions with chronically ill students, their families, classmates and school staff. Since the interventions that have been reported are often specific to one population, it is difficult to evaluate their merits as applied to other populations. What follows, therefore, is a list of suggestions for possible interventions. The value of the interventions will depend on the specific needs of the targets of intervention and on how well the intervention is adapted to those needs. The following list of ideas is categorized according to use with the chronically ill student himself, parents, siblings, classmates, and teachers, but the items listed under each category should not be considered to be exclusive to that category.

The Student

1. Having a teacher or someone else from the student's school maintain contact with the student when the student is hospitalized or homebound can be an important connection with the "normal" world for the student. Contact with teachers and friends is a means by which the student can keep up with what is going on back at school. This can make the return to school much easier for all involved.

2. Most school districts will arrange for hospital/homebound tutoring for students who are out of school for extended periods of time. Close coordination between the tutor and the regular classroom teacher so that the student is working on some of the same assignments as are his classmates not only can ease the transition back to school, but can also lend a sense of camaraderie with classmates.

3. Some students are not necessarily out of school for extended periods of time, but miss a lot of school through short, frequent absences. For these students, it may be possible to find a former teacher in the community willing to provide tutoring support on a volunteer as-needed basis.

4. Sachs (1980) recommends a written back-to-school plan for students with cancer who are returning to school. Such a plan for any student returning to school after an extended absence, especially after an absence following the initial diagnosis of a chronic illness or after a disabling/disfiguring accident can be a means of anticipating problems and being able to deal with situations efficiently as they come up. Having a definite written plan can also lend an important sense of control to all involved since there will be a much bettter idea of what to expect.

5. For students just entering school (kindergarteners) or for those starting a new school, whether that be a different building within the same district or a school in a different community, going in to meet the teachers and staff before actually starting school may help set both the student and teachers more at ease. This is also a good time to discuss any special procedures or needs (medication, snacks, rest time, etc.). Going to school a day early just to talk to the teacher after school can also make it easier for a student who has been gone from school for a long time. The contact with the teacher and the first step back into the classroom then has already been made. When the student starts back to school these are two less things to worry about and he may feel like he has a built-in ally in the teacher.

6. Involvement of the student in developing an educational plan and in making necessary adjustments in the school routine can only be helpful. Students are much more likely to go along with any plan developed if they feel some ownership of it. Also the input of the student may be very valuable in developing a working plan. Generally the student is very aware of what he can and cannot do. Furthermore, any plan developed should be reviewed periodically to see if it is still meeting the needs of the student in the best manner.

7. Most chronically ill students will not need direct special education services. Some, however, may have limitations which significantly influence their ability to progress academically without assistance. In these cases, an educational aide or spending some time in the resource room each day may be ways of providing extra academic help. This sort of service, of course, would be subject to approval by the school's special education team.

8. If school policy permits, for students who are not physically able to handle a whole day of school, the option of having the student in school for a few hours while still receiving homebound tutoring services should be explored. Other students may be able to stay in school for the whole day if one or more rest periods can be provided.

9. If the student needs help with tasks in school, consider having other students provide as much of this assistance as possible. For example, if the student is unable to write or to write very fast, classmates can take notes (make carbons of their notes, photocopy them later, etc.) for him or turn on a taperecorder. If the student is in a wheelchair, classmates can escort him between classes and help him go through the lunch line. By having other students involved as much as possible, the chances of the chronically ill student being isolated in spirit from classmates even though he is physically integrated into the school is reduced. This also gives the other students a chance to get to know him as a person and it demystifies the illness. It is important, though, that student assistance like this is carefully organized with responsibility clearly defined. It is perhaps best if specific students are assigned specific duties with arrangements for substitutes if a peer aide happens to be absent. For younger students, if there are tasks that peers cannot handle, perhaps arrangements can be made with an older student to help out. Every task that an adult needs to help a disabled student with should be carefully examined to see if there is some way that a peer can do it instead.

10. It is important to have a clear plan of action to follow in cases of emergency. For example, people need to know what to do if there is a fire drill and a student in a wheelchair is on the second floor. Even if the student is on the first floor, the nearest exit doors may be too narrow for the wheelchair or there may be steps involved. Students with a prosthesis, braces or other mobility impairments may also have difficulties which must be planned for. Again, the student himself should be consulted in planning for unusual contingencies.

11. Behavioral principles may be very useful in dealing with some of the treatment mechanics of chronic illness as well as with behavioral problems. Behavioral techniques have been suggested for improving adherance to diet in diabetic adolescents (Magrab & Papadopoulou, 1977), improving self-treatment procedures in hemophiliacs (Sergis-Davenport & Varni, 1983) and for dealing with such problems as crying in infants, disrupted sleep patterns, self-stimulation, poor self-image, somatization, and peer relationship problems (Capell & Bensman, 1979). The techniques used by these investigators are basic procedures such as token economies, systematic positive reinforcement, corrective feedback,

modeling, and monitoring. A comprehensive discussion of the use of behavior management principles with chronically ill and handicapped students may be found in Creer and Christian (1976).

12. One valuable service that an adult within the school setting can provide is simply to be an objective, caring person that the student can talk to (Adams, 1979; Fredlund, 1977). Sometimes all the young person needs is someone to talk to--someone who is not as invested in them and their illness as their parents and who may be more accessible and approachable than their physician. At other times the young person may be requesting help in solving a particular problem or dealing with a specific concern. Fredlund (1977) recommends listening carefully, then checking out with the student what the two of you might do about what the student has told or asked you.

13. Peer groups have become a fairly common intervention technique in schools and are used with a variety of goals in mind. There is almost no literature on the use of groups with chronically ill students, but Williams and Baeker (1983) report a successful experience with such a group in the St. Paul, Minnesota schools. Activities undertaken in this group included: writing definitions of each member's illness, talking about their feelings about the illness, discussing how their family felt about the illness (the hardest question and one which prompted a parent meeting), use of puppets to act out situations, discussion of general good health practices, talking about what they liked about each of the six group members, and discussion of current problems and concerns. Williams and Baeker found that over the twelve weeks that the group met, the students made gains in knowledge of their own illness, knowledge of others' illness, increased understanding that others with chronic illnesses have many of the same feelings, realization that they could trust other group members, realization that everyone has his "own cross to bear" and realization that they "were not freaks".

14. As mentioned earlier, a young person's ability to understand his illness and its ramifications changes with age. School people can play a valuable role in making available age-appropriate information to the student. Contrary to expectation, children and adolescents are often very uninformed about the basics of their own illness (Harkavy, Johnson, Silverstein, Spillar, McCallum and Rosenbloom, 1983). Often what information was given the student was given before he was developmentally able to understand it and by the time he is old enough to really understand this type of information, others may assume he already knows it.

15. Relaxation training may be a useful skill to teach a student who must deal with the extra stresses and anxieties associated with chronic illness.

16. Bibliotherapy can be a relatively nonthreatening way of providing support. This gives students a chance to find out about how others have dealt with situations similar to theirs and lets them know they are not the only one to have faced these situations. Books also provide a good starting point for further discussion. Notes from a Different Drummer, and More Notes from a Different Drummer are guides to children's and

young adult literature which provide annotated biliographies of fiction portraying a variety of handicaps. Volumes I and II of The Bookfinder provide annotated bibliographies of children's literature in general with indexing as to themes dealt with by different books. The complete references for these resources may be found at the end of this chapter's references.

17. The April, 1984 issue of The Exceptional Parent includes a description of a Boston organization known as Partners. This group operates much like Big Brother/Big Sisters but it matches handicapped children with adults with similar handicaps. The organization apparently is only active in Boston at this time, but the idea could be applied almost anywhere on a less formal and an individual basis. Contacting local volunteer agencies such as the American Cancer Society, the Epilepsy Foundation, or the American Diabetes Association, by contacting the student's physician, or simply by putting a notice in the newspaper may be ways of locating an adult willing to share some time and experience with a young person.

18. Vocational rehabilitation counselors can be a valuable resource for school personnel working with chronically ill students. Even if the student is still under the age at which the vocational rehabilitation counselor may work with him directly, the counselor may be willing to consult with school staff on useful classes the student might take. Prevocational and vocational counseling and training are also increasingly available under the umbrella of special education as well as through regular education in some high schools.

Parents

1. As with the student, one major thing school staff can do for parents is to listen. Bryant (1978) points out that repeating the story of the illness is one way that a family can grasp the reality of the illness, but the listener should take care not to make any assumptions about how the family is feeling about this crisis. She goes on to make an interesting point about saying 'Let me know if there is anything I can do...' This statement requires some sort of positive action on the part of those who are already faced with heavy decisions. It is better to notice what needs to be done and do it.

2. Parents may be afraid to inform the school of the nature of the child's illness because of concerns about how the child will be treated by the staff and other students. This, unfortunately, is a valid concern. But, for the most part, the school can much better serve the student if there is a free flow of information between parents, physicians and the school. The parents may need encouragement to make the necessary information available and help in determining appropriate information to share with the school on an ongoing basis.

3. If there are a number of students in the school with chronic diseases, school staff may want to consider organizing a support group for parents or at least facilitate communication between parents. For example, if a student has recently been diagnosed as having diabetes and the school

nurse knows of another student in the school with diabetes, she might make the two families aware of each other's existence and encourage contact between them. School people can also pass on information on community resources such as national and local chapters of associations dealing with specific illnesses and local parent support groups. See the appendix for a list of some of these organizations.

4. Information on general parenting skills may be needed by parents. School staff may also be able to help with dealing with some of the unique problems arising from chronic illness through use of behavior management techniques (see point eleven under Student).

5. School staff, particularly the school nurse and school psychologist may be able to help parents interpret medical information. If there are issues or concerns that the parent feels uncomfortable discussing with the physician and which cannot be adequately addressed by anyone else, a roleplaying situation can be set up to give the parent practice in asking these questions and to increase their confidence in dealing with professionals.

6. Since the student spends so much time in school, the school is in a good position to monitor the effects of treatment and to monitor whether treatment and medication regimens are being followed. If it does not appear that treatment procedures are being followed, a meeting should be held with the parents. It may be that the parents are unaware of the problem (as in the case of a teenager not following a prescribed diet), or they may not be adequately trained in the treatment procedures (for example, they may not fully understand the types of food their child can eat, or they may not be clear on exactly how to balance diet, insulin, and exercise in the case of diabetes). Parents also may not fully understand the importance of following a doctor's instructions exactly (for example, they may stop giving a course of antibiotics when it looks like the child no longer needs them, or they may short-cut sterile procedures in home factor replacement therapy for a hemophiliac son), the parents may be resistant to a treatment program because they do not believe in it, they may be unable to cope with a complicated or demanding treatment schedule or they may just be uninterested. When there are problems with treatment regimens, the school can be a valuable partner in working with the student's parents and physician to improve the situation.

7. If the family moves from the school, communication with the new school is important. Parents should be encouraged to contact the new school as soon as possible. If records cannot be sent ahead for procedural reasons, parents should be given copies of the most pertinent information to hand carry to the new school. Telephone contact between the person most knowledgeable about the student in the old school and the person most likely to have similar contact with the new school can do much to ease the transition. Contact of this nature, however, should be done with the knowledge and consent of the parents.

8. School people can facilitate communication between parents and their ill and healthy children. In many cases there is a kind of family taboo

about talking about the more sensitve aspects of the illness. It may be easier to address these issues with the help of a neutral third party. For example, a teenage girl with cystic fibrosis was beginning to rebel against her daily treatments. Her mother, a single parent who had sacrificed much in providing the extensive care that her daughter needed, was feeling that all of her efforts were unappreciated and that her daughter was deliberately trying to ruin the health that she had fought so hard to preserve. In talking to the mother and daughter separately the pediatric psychologist at the cystic fibrosis clinic they went to realized that they had never really talked to each other about what the disease, its uncertainties and its demands really meant to them. He got them together and asked one or two directive questions; they took it from there and got a lot of issues and misunderstandings cleared up.

9. Reading material can be especially useful because it is something which can be dealt with in chunks only as large as the reader can handle, it can be read and re-read and it is a means by which even parents in isolated areas can feel some sort of contact with others in the same position. The monthly magazine The Exceptional Parent and Audrey McCollum's book The Chronically Ill Child: A Guide For Parents and Professionals are two excellent resources. Both are written specifically for parents and contain a lot of practical information. One interesting feature of The Exceptional Parent is the letters to the editor section where parents who have children with extremely rare diseases write in and ask for others with experience with that illness to contact them--it is sort of a national bulletin board. McCollum's book is very comprehensive in dealing with issues of chronic illness from birth to adulthood. She takes a develpmental approach and gives practical information and suggestions on how to deal with issues that will arise throughout childhood and adolescence.

Siblings

1. Peer groups can be useful for siblings as well as for the chronically ill children. This gives them an opportunity to share experiences with others who are in the same situation and who understand the unique problems and stresses associated with chronic illness. If there are not enough children to form such a group within a school, perhaps a group sponsored by a community agency or medical center can be located.

2. Teachers are in an excellent position to watch for signs of stress and problems in students who have a brother or sister with medical problems. The teacher or someone else in the school should be willing to listen to questions and able to identify concerns even if they are only indirectly expressed by the student. Bergman (1978) recommends using what has been called "the third person option play". If the sibling is reluctant to talk about his concerns, the adult (teacher, school psychologist, school nurse, or someone else close to the student) might say something like, "When a brother or sister like yours gets sick, some kids I know worry that they might have done something to cause it even if they don't talk about it. Does that make sense?" Bergman lists three common responses to this type of statement: a) "No!"; b) "Yes, some kids might feel that

way, but I don't," and c) "Yes, I'm glad you mentioned it." The student's response can then give guidance to the direction of further discussion.

3. Siblings often know little about their sibling's illness. School people can encourage parents to keep siblings informed and can also help the student to find out more on his own. This could even be a project for class. The student might write a report on the illness and present it to classmates. This will not only increase his knowledge and his classmates' knowledge of the subject, but it can give him a feeling of having a special expertise.

4. For families who by choice or necessity must focus their attention and energy on a chronic illness, it may be difficult for a sibling to find his own identity and interests. School staff can encourage development of interests and can perhaps negotiate ways of pursuing those interests if family financial problems or transportation difficulties interfere. It is important that the student have an identity of his own and not just be known as "poor Billy Smith's brother".

5. Siblings with a brother or sister with a terminal illness are functioning under a special stress and if that brother or sister dies, the sibling may need help dealing with their grief. Anne Elbert's (1982) chapter "The Forgotten Ones: Helping Children and Adolescents Cope with Death" in Volume I of this series, can be useful in dealing with these situations.

6. As for the chronically ill student and parents, books related to the illness both fiction and nonfiction can be a good tool to use with siblings. Again, Notes from a Different Drummer, More Notes from a Different Drummer and The Bookfinder can be excellent guides in locating fiction appropriate to the young person's age and needs. A librarian should be able to help locate nonfiction material appropriate to the student's level of understanding.

Classmates

1. Classroom projects or a school-wide health day can serve to inform students about various health disorders. This can demystify otherwise mysterious medical problems and provide information in a more non-emotional, organized manner than having to deal with issues as they come up in relation to a specific student. This is also a good opportunity for students with various medical problems (or their siblings) to play "expert for the day" and to gain positive attention for the ways in which they are different. Young people often can do a much better job than adults of explaining their illness in a way that other kids can understand.

2. Death or serious illness of a classmate should never be ignored (Bryant, 1978; Fredlund, 1977). If information is not provided to children they will come up with their own explanations, generally inaccurate, of the situation. Bryant (1978) recommends that teachers make certain that children in the class know the details of a dying classmate's illness.

The illness of the child who dies should be separated from any medical problems classmates experience. The unusual nature of the situation should be stressed and emphasis placed on the fact that hospitals are places where people usually get better. And, as with siblings, the teacher needs to be sensitive to clues that students have questions even though the questions may not be asked directly.

3. Active involvement with a health disabled classmate cannot only benefit the ill student as discussed in point nine of Student Interventions, but it can be of benefit to the helping classmates as well. It is not only an opportunity for them to get to know the student, but it can lead to increased tolerance for individual differences, increased responsibility and a better sense of the value of cooperation and interdependence. The healthy students may also come to feel a personal investment in making the school experience as successful as possible for their fellow student.

School staff

1. Teachers generally do not know much about chronic illnesses yet it is generally acknowledged that the more knowledgeable the teacher and other school staff are, the better they can serve the student. Increasing attention is being paid by medical workers to the information needs of teachers. Inservice efforts by Miller and Anderson (1979) and Ross (1984) relating to cancer in children both resulted in positive changes in knowledge about cancer and attitudes toward children with cancer. Informational sessions like this can be conducted by out-of-school people or in-school people either in groups or individually. In individual sessions, staff may feel more free to ask questions and express concerns, but they may miss out on input from other group members. Care also should be taken not to exclude members of the staff from such information sessions just because they do not generally have direct contact with the student. Even teachers who will not have the student in class, may have some contact with him outside of class and generally have contact with other students and staff members who are involved with the student. Any person within the school setting can potentially be influenced by or influence the health impaired student.

2. Chronic illness in a young person is a very emotion-laden situation, especially if the illness is potentially fatal. Just like parents, teachers and other adults close to the child may need support in dealing with the reality of serious illness. Often all that is needed is someone to talk to about the illness and its impact. This listener may be a school nurse, school psychologist, social worker, counselor or principal or just another teacher, especially if that teacher has had to deal with a similar situation.

3. The more involved a teacher is in developing an educational plan for a student the more investment there is in seeing that that plan succeeds, especially if it places unusual demands on the teacher. There are much better chances of cooperation if a teacher is approached with "Johnny is going to need to have a snack twice a day--how can we work that into your schedule?" rather than "You have to be sure that Johnny always has

a snack break at 11:00 and 2:00." It also helps if the reasons for special accomodations are carefully explained and discussed with the teacher. Teachers often can anticipate problems and see solutions that others may not think of.

Monitoring

Monitoring of ongoing needs of the student with a chronic illness and the others impacted by the illness is perhaps most easily accomplished by having one person within the school designated as a case manager. Since the student will change classroom teachers from year to year, this person may logically be the school nurse, school psychologist, social worker, counselor, special education teacher, or even principal or assistant principal. This person can make a specific effort to be aware of how things are going for the student and can serve as a central point for fielding concerns of others who deal with the student. If problems arise the case manager may opt either to deal with them directly or to consult with and possibly refer the student to other support personnel within or outside the school. This person can also serve as the school's main contact person with the family maintaining awareness of the family situation and how it may be affecting the school performance of the health impaired student and school-age siblings. Depending on the individual situation, the case manager may have minimal contact with the student and family or there may be a great deal of contact necessary. Also the need for involvement may vary as the course of the illness varies. To make this sort of system most effective, all school staff should be aware of who the case manager is and what sort of information should be brought to this person's attention.

Conclusions

Chronically ill children and adolescents often are dealt with in a rather haphazard, solve-the-problems-as-they-come-up manner in the schools. Not only can this approach be inefficient, but the effectiveness of any interventions may be marginal at best because it is likely that the problem solvers are not fully aware of the student's situation and the ramifications of the illness. Information is important in dealing with the students with health impairments, but information on chronic illness is sorely lacking in educational literature. These are often students with special needs, but special education teachers trained to teach the mentally disabled, learning disabled or behavior disabled students are frequently as unfamiliar with the chronically ill and their needs as are regular classroom teachers. Currin (1979) found that in one group of health impaired students, for those areas which are most frequently linked to poor achievement and behavior problems (coordination problems, muscle weakness, other physical problems, medication to control hyperactivity) some assistance was received by the students, but the frequency and type of assistance did not match the observed need.

General information on the needs of the chronically ill is needed by educators to provide a basis for the specific information needed to serve the unique needs of individual students. Experience in dealing with health impaired students can be helpful, but care must be taken to avoid assuming that what may have been true in one situation will be true in another situation no matter how similar the situations may seem to be.

The main responsibility of the physician in regard to a young person with a chronic illness is to treat and control the illness. The main responsibility of the school in regard to a young person with a chronic illness is to help that child or adolescent (and school-aged siblings) to function in the school--in everyday life--as well as possible, in other words, to facilitate coping. In a two-year study of families of leukemic children, Kupst, Schulman, Maurer, Honig, Morgan and Fochtman (1984) found most families to be coping well. However, the authors point out that coping does not mean the absence of problems, severe emotional upsets, or the occasional incidence of defensive behavior. In fact, coping took on may different forms:

> Some people focused on problems connected with the illness, while others minimized the severity of the crisis. Some freely showed their feelings of anxiety, apprehension, sadness, or anger, while others maintained a cheerful or positive attitude. A number of family members relied on religion or faith, but many did not. While open communication and an attitude of living in the present correlated with coping, the influence of other modes and strategies was unclear. (p. 160-161)

"Coping" in this study was based on judgments by medical, nursing and hospital psychosocial staff as well as by families themselves. There was no direct input from the child's school, but it is likely that if there were major problems in school this would have affected the ratings. As already noted, coping does not mean the absence of problems. And, just because a family and a student seem to be coping well overall with the illness, this does not mean that there are not issues and problems that need to be addressed. The need for active involvement in the management of the illness and its ramifications may vary greatly during the course of the illness, but even when active involvement is not necessary, the situation should be monitored so that small problems can be dealt with before they become big problems.

Working with a chronically ill child or adolescent can require much sensitivity, creativity and emotional commitment, especially when the illness is considered to be terminal. The best service can be provided when all people involved in the young person's care, including the young person, can work together as a team. This may take some effort and negotiation--medical, social service, and educational personnel can all be very protective of their own turf. But, the goal of all involved is to help the young person because he is the one who ultimately must deal with the illness, its uncertainties, and its long-term implications.

Footnotes

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Appendices

There are numerous organizations which serve people with chronic illnesses/low incidence handicaps. Some of these organizations are listed below; addresses are not listed because they frequently change. For addresses of these and other relevant organizations see the current edition of Gale Press' Encyclopedia of Organizations. If your local librarian does not have access to this reference book, contact your regional library or area INFORMS representative.

American Diabetes Association
Arthritis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Juvenile Diabetes Foundation International
Leukemia Society of America
Little People of America
Muscular Dystrophy Association
National Amputation Foundation
National Association of the Physically Handicapped
National Ataxia Foundation
National Easter Seal Society for Crippled Children and Adults
National Foundation of Ileitis and Colitis
National Foundation/March of Dimes
National Hemophilia Foundation
National Paraplegia Foundation
Osteogenisis Imperfecta Foundation
Prader-Willi Association
Society for the Rehabilitation of the Facially Disfigured
Tuberous Sclerosis Association of America

Perhaps the best information source in identifying available resources is:

Closer Look
National Information Center for the Handicapped
Box 1492
Washington, D.C. 20013

Stealing

R. Michael Weger

Abstract: Although relatively rare as a reason for referral, stealing is a pervasive problem which for some, signals the beginning of chronic maladjustment. This chapter provides an in-depth look at stealing from a variety of diagnostic and treatment perspectives. These contents will provide information important for individuals, schools, and communities as they deal with stealers. The school psychologist could be a key figure as he is part of the second largest continuing experience of most children—education.

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Introduction

Stealing is a pervasive and most expensive problem in America today. Belson (1976) reports that during the school year approximately 9 of every 10 boys indulges in stealing. However, although Klemke (1982) found that approximately two thirds of his sample of 1,189 youth had engaged in stealing (shoplifting) most of them had only limited involvements and could be described by Cameron's (1964) term "sporadic pilferers." Although the rate of stealing in general is internationally lower for females versus males (Hampton, 1975) an informational pamphlet by the C.L. Bete Company (1983) indicates shoplifting is a major form of stealing in America, that young people (under 18) make up one-half of all shoplifters and that girls greatly out number boys. They add that one in every ten people shoplift and that most shoplifters come from middle income, suburban homes. Many studies that report on the incidence of shoplifting involve adult populations (Robin, 1963; Cameron, 1964; Won and Yamamats, 1968). These studies would suggest that more females are apprehended for shoplifting.

Not all agree on the sexual differentiation in favor of girls being more involved in shoplifting. However, the contradictions may simply relate to differences in the time of life sampled. Klemke (1982) studied 1,189 youth in four high schools using a self-report questionnaire. Students reported on their recent shoplifting behaviors. In this study males reported more shoplifting of three different items value levels ($2, $2-10, $10+) than females. Klemke suggests that perhaps males shoplift more early in the life cycle while females become more active in later adolescent phases and young adulthood. This might also relate to a sex difference in who is apprehended more often—males or females. Klemke found that 30% of his male sample got caught by store personnel while only 20% of females were apprehended. Overall, shoplifting declined as the youth, male and female, moved into mid-adolescence. He indicates this is contrary to the prevailing Adolescent Crime Wave model. His Declining Adolescent Crime model is expanded in another work (Klemke, 1978) and may only be true for shoplifting.

Shoplifting is very hard to detect and many who are caught are not formally processed. Hindelang (1974) reported that only 26% of apprehended shoplifters are reported to the police. It is especially unlikely that a child under the age of ten will be formally processed (Klemke, 1982). Street names for shoplifting or stealing are "pinching," "ripping off," "hooking," "liberating," "borrowing," or "snitching." In general, shoplifting is legally termed larceny. More specifically the 1983 State of Iowa Criminal Code (1983) defines it as 5th Degree Theft[1]

FBI Crime reports (1979) indicate a 19% increase in shoplifting from 1974 to 1978. It is the fastest growing form of larceny. By 1971 the average value of stolen items in each incident was $25.00. In 1974 the National Retail Merchants Association reported 3.5 billion nationwide losses due to shoplifting. That's 10 million dollars per day! Now 5 billion is reported lost every year resulting in two to three cents of every dollar spent being needed to cover these losses, pay for security, legal costs, etc. (C.L. Bete Company, 1983). The United States Bureau of the Census (1979) reports that juveniles are involved with 59.5% of all car thefts, 52.3% of all breaking and entering cases, 37.8% of the larceny committed in America and 29.5% of all robberies.

In Scott County, Iowa, 540 juveniles were apprehended in 1983 for various legal forms of stealing. Of these, 216 were for theft other than shoplifting, 175 were for burglary, 137 for shoplifting, 6 for robbery and one for attempted burglary. The Scott County, Iowa, Juvenile Diversion program reports that 90% of all juvenile arrests are shoplifting incidents, that the average age of these juveniles is 11 to 14 and lowering with time and that many of these kids admit to having shoplifted before but not being caught. Repeat shoplifters go to juvenile court and many adult offenders were juvenile shoplifters. Scott County Juvenile Court Services spends approximately 94.00 dollars per case handled. This does not include court costs which are an additional burden to taxpayers. In the past all incidents of shoplifting were not reported. Now, stores are encouraged to prosecute each case and court action is taken on the first incident.

Rosen and Rosen (1983) indicate stealing is not a widely studied phenomenon because it is hard to detect, difficult to effect consequences and because of ethical considerations. However, it is a major problem and merits both study and treatment efforts. Reid (1975) indicates that approximately one half of all children referred for social aggression are also in trouble for stealing. It is an accelerating phenomenon with an average 25% reduction in time between convictions (Crockett, 1973). Several years ago the re-conviction rate for delinquents was approximately 88% (Jeffery, 1967). Several authors have reported an increasing likelihood of chronicity with each offense of stealing. Moore, Chamberlain, and Mukai (1979) found that 92% of first offenders yield a second offense, 91% of these yield a third and 80% yield a fourth. Wolgang, Figlio & Sellin (1972) found 54% of first offenders yield a second, 65% of these yield a third and 72% of these yield a fourth offense.

Youngsters with identified stealing problems are at greater risk for later adjustment/legal problems than youngsters identified by other means. In fact, they are five times as likely to be involved with the police or court system as are oppositional or aggressive kids. Children that present problems of control or management are not nearly as likely to be involved with the law as those who engage in covert social actions such as lying and stealing. Parent reported stealing events are highly predictive of later delinquent status (Moore, Chamberline & Mukai, 1979).

Definitions: Legal and Practical

Theft: "A person commits a theft when they take possession of the property of another, without the owner's permission, with the intent to deprive them of that property. A person also commits theft when they exercise control over stolen property knowing such property to have been stolen or having reasonable cause to believe that such property has been stolen."

5th Degree (0-$50)	30 days in jail and/or $100 fine.
4th Degree ($51-$100)	1 year in jail and/or $1,000 fine.
3rd Degree ($101-$500)	2 years in penitentiary and/or $5,000 fine.
2nd Degree ($501-$5,000)	5 years in penitentiary and/or $1,000 fine.
1st Degree (over $5,000)	10 years in penitentiary and/or $5,000 fine.

Robbery: "A person commits a robbery when, having the intent to commit a theft, the person does any of the following: (1) commits an assault, (2) threatens another with serious injury, (3) threatens to commit immediately any forcible felony."

There are two degrees of robbery

1st Degree - with a dangerous weapon - 25 years in penitentiary
2nd Degree - 10 years and/or $5,000 fine.

Burglary: "A person commits a burglary when, having the intent to commit a felony, assault or theft, he/she enters an occupied structure or area closed to the public without permission of the owner."

There are two degrees of burglary:

1st Degree - with a dangerous weapon - 25 years in the penitentiary.

2nd Degree - 10 years and/or $5,000 fine.

The above are legal definitions of stealing obtained from Juvenile Court Services in Scott County, Iowa. Children from birth to age 18 may come within the jurisdiction of the Juvenile Court.

These legal definitions are not necessarily helpful in treating the problem, however. Dr. John Reid (1975) points out some problems in defining stealing that add to the difficulty of its treatment. Parents are usually inconsistent in labeling a stealing event. They need to feel assured that the child has willfully taken or stolen something that belongs to someone else and that the owner would not have given that thing voluntarily to the child. This kind of definition focuses on the childs intentions or motivations and not on the specific behavior—stealing or taking—which, if competently executed probably would not be observable. Parents tend to attach a variety of labels to behaviors that could be called stealing, e.g., being given something, borrowing, loaning, finding, or winning things. Accepting such labels when a child has items in his possession of unknown origin brings about a monumental problem of proof. Parents may feel they have no grounds to punish if they are not positive a theft has occurred.

Many times parents are informed by reliable sources that their child has stolen something. In such instances the child will often put the parent in the position of trusting (believing) him/her or the informant who is, of course, "against" the child. Although even the most prolific thieves may be unjustly accused at times, siding with the child in such instances leaves the parent with nothing to do about the problem, if there really is one. Siblings can compound this issue of "who do you trust--me or them" as they blame each other.

The issue of value also interferes with a parents willingness to appropriately label stealing behavior. They often feel that punishment is not warranted because of the meager value of the stolen item. Thus, says Reid (1975), the child becomes armed with a powerful tool—one of comparison.

Dr. Reid (1975) argues that theft is not all that abnormal and that almost all children have probably stolen something sometime. Indeed, Belson (1976) reported that 88% of school age boys have stolen at least once. The problem for the client, is the amount of thievery, the value of the thefts and that he is labeled as a thief. This last concern may be the most important because it seriously impacts on how others see the child. If people perceive a child as a thief but never catch him/her, even if they have stopped, other's will likely think that he/she is more clever and simply hasn't been caught.

Reid (1975) indicates that the main goal for stealers is not just to stop stealing but also to stop being accused. They must not only stop doing wrong, but also avoid the appearance of wrong doing. This may necessitate major behavioral changes such as not staying out late at night, dropping out of certain peer groups, being accountable for all possessions, etc. To eliminate these definitional problems and facilitate treatment, Reid (1975) defines stealing as:

> "the childs taking or being in possession of anything that does not clearly belong to him/her" (p. 137).

Parents are the sole judges who label the stealing. They may label an act as stealing by witnessing it themselves, viewing the stolen property, or by report from a reliable informant, i.e., teacher, police, principal, etc. There is no arguing about whether or not the child is guilty. He/she may be unjustly accused at times but it is his/her job to avoid being accused. The value of the object is irrelevant and anytime he/she is "given" something or "borrows" an item they must be able to prove it. Reid suggests that children refrain from bringing anything home until the stealing problem is under control.

The reader is referred to the treatment section of this chapter to see how Reid combines this definition of theft with a specific treatment program.

Etiology: A Variety of Perspectives

We are apt to be satisfied when it appears that an act of stealing has been committed because of some apparent gain but this is not always the case. Reinforcers supply needs and needs are individual and not always apparent from the behavior and/or consequence involved in their satisfaction.

Some have categorized stealing into types with each having a corresponding motivation. Lambert (1976) describes compulsive, mischievous and malicious stealers. The first, he believes, is the result of a "severe" behavior problem. Mischievous theft relates to boredom and/or hostility and is often done by more than one child. The last is motivated by anger and is deliberate in order to hurt someone. Reutzer (1972) described rationale stealing, motivated purely by gain; social stealing, due to peer pressure; the stealing of a psychopath; sporadic-aggressive stealing which is largely anti-authoritarian and kleptomania—theft motivated by some emotional concern.

Stealing is viewed by a variety of authors from a variety of perspectives. There are those that see it primarily from a behavioral point of view but others who view stealing as a symptom of underlying emotional dynamics. Some believe that the family and environment produce stealers, others point the finger at public education and others, very conservatively feel that thieves choose to be thieves and that only they are responsible.

Behavioral:

It is easy to see from a behavioral viewpoint why stealing might occur and how it is maintained. Traditional control procedures are based on weak and delayed reinforcers. Since the majority of behavior is good or, at least, acceptable, it tends to be expected and overlooked. Thus, it is not nearly as often or as strongly reinforced as a successful theft would be. Stealing behavior is subject to inconsistent positive consequences and therefore develops the strength found with an intermittent schedule of reinforcement. Stealing is usually reinforced immediately by the item, any internal conditions (feelings of triumph, power, etc.) and often by peers and/or the teacher (Stumphauzer, 1976) Lastly, say Rosen and Rosen (1983) thieves are usually not identified until several successful acts have been committed and thus stealing is well established in their behavior repertoire. Successful stealing, without punishment, is a strong conditioning event which yields important but dangerous positive feedback (Renshaw, 1977).

Henderson (1981) indicates that successful theft has an immediate payoff and thus certain stimuli, both internal and external, will recur coincidentally with this behavior and acquire discriminative or secondary reinforcing properties. This yields a backwards chaining effect which will draw the subject to repeated acts of theft.

The usually subtle but powerful reinforcing effects of either direct or unconscious parental approval must also be considered in terms of learning and maintenance of stealing behavior (Johnson, 1945; Renshaw, 1977; Stumphauzer; 1976). The behavioral response of parents to their childs stealing is also hampered by a sociological twist. That is, the increasing isolation of the family within each neighborhood makes it difficult for parents to get feedback about their childs behavior out of the home. Stealing is usually not confined to the home and thus consequation of out-of-home stealing is weak or non-existant. This yields the potential for stealing behavior to become established before it can be treated (Reid, Rivero and Lorber, 1980).

Sociological:

Beck and McIntyre (1977) describe stealing; shoplifting in particular, as a "resultant behavior" and feel that one cause is environmental temptations. Poret and Brombert (cited in Arboleda-Florez, Durie & Costello, 1977) spoke of "extrinsic" causes of stealing and cite, in particular the way goods are displayed in stores, on television, etc. Mack (1978) speaks of the "attractive nuisance" at school. That is, the tempting things children see that are laying around, sticking out of pockets, on the teachers desk, etc. He feels these are strong motivators for stealing at school and indicates food and money to be high temptation items.

Klemke (1982) reports three major sociological perspectives relative to the cause of delinquency. First, it is generally agreed upon that youth experiencing problems within their major social involvements (money, home, school) are more susceptible to delinquent involvements. This is the deviant vulnerability hypothesis. Investigations of the motivation behind shoplifting indicate economic, sporting and peer pressure factors. Surprisingly peer pressure was weakest (as a self-reported motivator) but is likely indirectly related to the economic and sporting motivations. Renshaw (1977) also considers peer pressure a factor but does not quantify its strength. Because of the variance in strength of factors however, Renshaw concludes there is "modest" evidence for an economic vulnerability factor related to shoplifting among youth. Cameron (1964) felt that stealing was related to attitudes that we all must be equal, middle-class people. Efforts to be what one is supposed to be can yield aberrant behavior and depression. Rezvani (1983) reports greater property crime in areas of higher income inequality and Henigan (1982) relates the concept of "relative deprivation" to theft through televisions' portrayal of reality. Thus economic problems, real or perceived, may be quite motivational.

Part two of this first theory relates to the family relationship. Many would agree that a childs parents and family are a major source of attachment to the social order. Linden and Hackler (cited in Klemke, 1982) report more frequent shoplifting activity by youth having "problems" with their parents and a moderate relationship between this and shoplifting (-.23 for father & -.22 for mother). Sex is important as the relationship for sons and fathers was -.30 but only -.15 for daughters and mothers. Zabczynska (1977) examined a number of factors during a five-year follow up of 100 boys charged with theft. Major environmental factors impacting on social adjustment were "extremely negative" home environments characterized by alcoholism, criminality, associated bad rearing and often total neglect. Prognostic indicators for later social problems were running-away, alcohol, school failure before the age of 11 and stealing. In sum, problems at home yield a greater likelihood of problems with the law. Johnson (1945) and Renshaw (1977) indicate that some youth identify with their dysocial families. Thus, a child may engage in stealing in part because of family problems or to be like their family or at least certain members of it. The Scott County Iowa Diversion Program has reported treating stealers who were sent to shoplift by adults who paid them a percentage of the profits from the "hot" items and assuaged their fears by telling them they wouldn't be prosecuted because they're "just kids." For more about the impact of the family and especially parenting the reader is referred to the section titled. Moral Development: Family Impact. The quality of both the relationship and the style of management impact on the risk of delinquent behavior in children.

The last of the first theory's factors relates to the interaction of education and delinquency. Klemke (1982) concludes that there is a strong relationship between academic performance (-.36) and school attitude (-.33) and shoplifting. School experiences were more powerful predictors than economic or family variables. Polk and Schafter (1972) report that schools restrict opportunities for some students and delinquency is the result of "blocked goal attainment."

The second major sociological theory relates to deviant labeling. That is, stigmatizing reactions by others may foster deviant self-concept formation and involvement in delinquency. Klemke (1982) concludes that there is a strong relationship between being labeled a "trouble maker" (1) by oneself (.40) and (2) by ones teacher (.45) and shoplifting. The relationship was strongest for lower blue-collar class youth. He also indicates that contrary to previous studies (Cameron, 1964; Gold, 1970; Rezvani, 1983) more youth who had been apprehended by the police reported shoplifting and doing so more recently. Applebaum and Klemmer (1973) also report that the harassment of having charges pressed, a court hearing, trial and probation does not seem to ameliorate delinquent behavior or further risk taking. Klemke suggests that the apprehension—labeling experience may produce more amplified deviance versus deterring it. On the other hand, the deviant behavior may have increased the likelihood of being labeled. Hirschi (1975) asserts that more evidence favors this later position. Samenow (1984), on the far right, asserts that criminals are only labeled after they deserve it. Society did not cause this persons behavior by labeling it. Yet, psychology keeps reminding us of the effects of labels and self-fulfilling prophecies.

The third and last sociological perspective is relative to deviant socialization. Klemke (1982) indicates youth are more likely to shoplift with someone than adults. He found a weak but positive relationship between number of friends and shoplifting (.11). Linden and Hackler (cited in Klemke, 1982) reported that in all cases recent shoplifting activity was much more frequent for youth who knew significant others (parents, siblings or close friends) who shoplifted. They also reported a strong relationship between shoplifting and having friends known as "troublemakers" by teachers.

Internal Conflicts

In addition to the external perspectives of sociology and behaviorism, investigations of stealing behavior have yielded numerous explanations involving internal/psychological conflict. Poret and Bromberg (cited in Arboleda Florez, Durie & Costello; 1977) spoke in general of intrinsic and personality problems relative to stealing. Rudolph Dreikurs (1964) in Children the Challenge, reports that lying and stealing are symptoms of deeper, underlying rebellion. Arboleda-Florez, Durie & Costello (1977) speak of relief from personal dilemmas through stealing.

Although there does not appear to be a specific personality structure for stealers (see Assessment: A Stealing Personality) Bradford and Balmaceda (1983) argue that in their sample of 50 adult shoplifters a typical profile of psychiatric concerns and related antecedent events surfaced. A "typical" shoplifter referred for psychiatric evaluation is a 37 year-old married female, employed at the professional end of the occupational spectrum, who is suffering from a depressive neurosis, and who, prior to the theft, experiences a high level of psychosocial stress and subsequently stole an item of insignificant value or use to herself. Many of these people have symptoms of dissociative amnesia at the time of the theft. The clinical picture is usually not sufficient to warrant a diagnosis of psychogenic amnesia but rather suggests a pre-occupation or absent-mindedness in relation to a stressful life event. They argue that this phenomenon is so strong that Automatism could be recommended as a legal defense wherein the shoplifter may be judged to be of diminished capacity. Zorick, Salis, Roth, and Kramer (1979) did indeed present a case of narcolepsy with shoplifting as an associated automatic behavior. These authors are suggesting a state of reduced consciousness due to personal problems. Others would suggest adequate consciousness but poor judgment (Millman, Schafer & Cohen, 1982; Renshaw, 1977). Millman, Schafer & Cohen speak of a momentary lack of judgment. Thus, depression, shoplifting and adult females are related.

With male adult shoplifters, Russsell (1973) noticed a significant presence of schizoid personality structure. He also advanced several explanations for stealing such as: subconscious suggestion, fetishist tendencies, disguised erotic satisfaction, a form of affective compensation and a manifestation of depression. Other authors have also reported that depression is common in shoplifters (Gibbens & Prince, 1962; Gibbens, Palmer & Prince, 1971; Medlicott, 1968) and that thefts could be a depressive equivalent (Renshaw, 1977). That is, a behavioral acting out as a defense against depression. A depressed housewifes' shoplifting spree might be an example.

In adults, unfulfilled emotional needs, especially relative to early deprivation and feelings of unfulfillment are thought to relate to shoplifting (Russell, 1973). A variety of reasons, many of which are similar, are advanced for the stealing of children also.

Many authors speak of stealing as a way to get attention (Dreikurs, 1964; Mack, 1978; Millman & Scharer, 1982; Renshaw, 1977; Salk, 1972; Stumphauzer, 1976). Salk (1972) feels that stealing is one way for a child to "penetrate his parents attention barrier." Others feel stealing is a way of reclaiming lost love or general happiness (Mack, 1978; Renshaw, 1977; Revere, 1982). John Steinbeck wrote in East of Eden:

> The greatest terror a child can have is that he is not loved and rejection is the hell he fears. ...and with rejection comes anger and with anger some kind of crime in revenge...One child, refused the love he craves, kicks the cat and hides his secret guilt; another steals so that money will make him loved and a third conquers the world-and always the guilt and revenge and more guilt.

Revere (1982) writes of the pleasures of shopping and how, albeit ephemeral, possessions bring us happiness. Stealing such "pleasures" and symbolic happiness is trying to satisfy one need with another; something akin to compulsive eating. Once they feel rejected some children get into things instead of others. Mack (1978) feels some children are "anal retentive" and become "pack rats". They steal all sorts of little items so they can have them as if these possessions bring happiness. He believes many of these items are faddish, suggesting a succumbing to peer values of worth. Thus, such children are needy and find independent decisions difficult. Peers even influence their choice of items to steal. Children sometimes get caught up in their folly (Mack, 1978), not knowing how to stop. It is the only way that has succeeded in obtaining for them attention and recognition. Their neediness yields poor judgment, theft and consequent guilt and lessened self-esteem; a downward circle of trying to be fulfilled. Karson and O'Dell (1976) speak of the adolescent circle (G- & O+) on the 16 PF personality questionnaire. That is, super-ego alien behavior motivated by emotional need that overcomes judgment but which is then reflected in greater insecurity and apprehension—more concerns about adequacy.

Such self-centeredness or self-love is viewed analytically under the label narcissism. Psycho-analysts have written of stealing in relation to the concept of narcissistic revenge or revenge stimulated by narcissistic hurt (Tedesco, 1974; Kligerman, 1974). Stealing, say some psycho-analysts appears to have frank symbolic meaning even when superficially this is obscured by realistic gain. The act of stealing has a variety of discernible meanings, all of which are restitutive (Tedesco, 1974). That is, it serves first to undo a loss which is subjectively perceived as a theft where the patient/client has been the victim. Second, it is seen as an opportunity for revenge, for settling a score. Tedesco (1974) believes stealing and revenge are closely linked and that stealing is a way of taking initiative, of secretly converting a passive experience into an active one. It is also, he says, a way of controlling a frightening and dangerous object by reinstating a long-lost but cherished sense of omnipotence. The omnipotence comes from the power, triumph and possession subsequent to a successful theft. Stealing is often preceded by fantasy of having been the victim of a prior theft. This prior theft is not necessarily of a material object but may be stolen love, attention, respect, etc.

Thieves that steal without apparent guilt must convince themselves that they need not feel badly about stealing because of the privation and damages they have incurred. Thus, they develop a sense of being exceptional, that the world owes them and they have a right to what they want because of prior deprivations/lossen.

This feeling of entitlement is traced to the infantile sense of omnipotence (Kligerman, 1974). However, these feelings of "being owed" are a "regressive maldevelopment" related to a lack of empathetic understanding by cool and distant, perhaps even cruel and hateful parents. The child therefore fails to adequately internalize aspects of his parents necessary for a sense of completeness and self-esteem. The result is poor self-esteem and inadequate object relations. Such children do not develop a set of ideals that will protect them from their delinquency nor do they have the ego strength to protect themselves against narcissistic hurt. Thus, in the G-/O+ adolescent circle (16PF) reported by Karson and O'Dell (1976), stealing temporarily makes a person feel good, powerful, whole, etc, but in the long run it only further damages self-esteem.

Beck and McIntyre (1977) believe stealing, shoplifting in particular, may relate to depression engendered in the first three stages of psychosexual development. Belson (1976) and Renshaw (1977) feel stealing may simply be related to a desire for fun and excitement. Thus, a sense of omnipotence or over-inflated cocksureness may yeild a feeling of invulnerability relative to being caught. Dreikurs (1964) agrees that some children delight in not getting caught. He would also agree that some children steal because they feel they have a right to anything they want. Hudgins and Prentice (1973) refer to the egocentric orientation of the delinquent who looks at the world in terms of how it can satisfy him/her. The needs and concerns of others are obscured by self-centeredness and emotional neediness.

Persons with inadequate ego strength tend to copy the behavior of others and have trouble with independent decisions. This certainly impacts on those children that live with or witness, in parents or peers, acts of theft (Belsen, 1976; Levine & Kozak, 1979; Revere, 1982). Robins (1966) reported that 84% of parents of delinquents were either alcoholic or sociopathic. Peer pressure is, of course, an all important factor and can be a direct or indirect press on a child (Belson, 1976, Mack, 1978; Millman, Schaefer & Cohen, 1982; Levine & Kozak, 1979, Revere, 1982). That is, a child may steal in order to buy friends with the act or the merchandise. Peers may specifically coerce stealing or simply only attend to another child in return for "hot" items.

Dreikurs (1964) feels that if a child denies his stealing behavior, his motive is power and several authors have indicated that theft may possibly be related to anger at parents or authority in general (Mack, 1978; Millman, Schaefer and Cohen, 1982; Renshaw, 1977; Revere, 1982). Such indirect anger or rebellion might be expected from shy and introverted children. Threat sensitivity (H+ on 16PF) is correlated with schizoid personality in later life and/or under stress. Such children are often well behaved on the surface as they dare not rebel directly but do so in a covert and furtive fashion.

Revere (1982) reminds us that poor ego strength is related to trouble resisting temptation, and Renshaw (1977) feels stealing may also be related to poor impulse control, as a substitute for sex (housebreaking in teens who report ejaculation upon entry of the house), a reaction against a dependency struggle for autonomy "I can live on my own") or to a distortion of reality as in psychosis.

Just as some feel that suicide behaviors are misguided attempts to get help for personal problems there are those that feel this way about stealing. Millman, Schafer & Cohen (1982) feel that stealing is a plea for help with psychological problems while Beck and McIntyre (1977) describe stealing as a "covert call for adjustment assistance."

In a more conservative and less sympathetic perspective, Stanton Samenow (1984) would down play any factor except free will and self-control. He argues that criminals choose to commit crimes and that their environments do not make them do something against their will. He regards criminals as victimizers and not victims. Poor environments must be changed but we must not expect criminals to change because of it. Sociologists feel that character is molded by the environment like clay. Samenow argues that criminals have their own character devoid of environmental pressure and that they often shape the character of others as much or more so than the obverse. He points out how most impoverished, mistreated and traumatized people do not become criminals and feels there are no clear reasons for criminal behavior. Despite numerous differences, Samenow argues that criminals are alike in how they think. He believes most criminals are self-centered, want to be in control and are shallow in their interpersonal relationships. Their acts usually have sinister and/or selfish motives—even acts that on the surface appear altruistic.

Biological Factors

Biochemistry and neurology are discovering human characteristics unique to a variety of types, syndromes, behaviors, etc. The behavioral category of "stealers" is no exception as there are numerous suggestions in the literature that they indeed may have some specific biological correlates.

A particular kind of stealing, shoplifting, has been related to hypoglycemia, amnesia and absent-mindedness (Cunningham, 1975; Russell, 1973). Renshaw (1977) listed twenty-three reasons for stealing—four of which were subsumed under "biological factors." She refers to an "instinct theory" but indicates there is no supportive evidence and this author found nothing relative to this in a rather extensive review of the literature. Renshaw also cites physiological needs i.e., hunger, thirst, drugs, etc., and genetic factors such as the XYY syndrome often found disproportionately high among criminals. Beck and McIntyre (1977) speak of "delinquent" or "criminal" personalities and yet there does not appear to be a thief specific personality profile. Yet, the idea of a "bad seed" hangs on. Renshaw's last biological factor is called "immaturity" and relates to cognitive immaturity or retardation. James Comer (1980) would argue that certain age children are unable to understand concepts such as ownership, buying, selling, permission to use others property, etc. Both Comer and Renshaw (1977) believe that by the time a child is 7 or 8 years of age he/she should comprehend these concepts and thus is capable of stealing. Retardates will need to be treated more in line with their mental age (Jackson & Haines, 1982). Khan and Martin (1975) describe a case of cortical atrophy wherein a major presenting symptom is stealing. Various authors have indicated that, especially for adults, depression is the most common psychiatric concern (Gibbens, Palmer & Prince, 1971; Gibbens & Prince, 1962; Medlicott, 1968). There is a great deal of literature discussing the possible biochemical and neurological substrates of depression, other mental health concerns and even biological bases for certain personality characteristics.

The 16 Personality Factor Questionnaire by Raymond Cattell is known to most school psychologists and at least one of its factors is related to risk-taking behavior—factor H. This factor is related to a subject's boldness, adventurous and being thick-skinned and socially bold (Cattell, Eber & Tatsuoka, 1970; Karson & O'Dell, 1976). In 1957, Cattell argued that there were strong hereditary components to this factor—particulary to its positive expression-boldness. His 1973 work does not argue as strongly but does support this notion of a genetic predisposition for the qualities embodied by this factor. Cattell (1957) indicates there are neurological differences in people of high and low H factor scores. The H+ person is one in which the normal parasympathetic predominance is not easily shaken by the sympathetic nervous system or other interrupting responses. The sympathetic nervous system is that which responds to real or perceived threats in the environment. Thus, the less threat-sensitive a person is, all things considered, the more likely he/she will take risks. Applebaum and Klemmer (1973) report that adolescent shoplifters are more likely to engage in risk-taking then adolescent non-shoplifters.

Kleptomania, a special form of stealing is listed in DSM-III as a disorder of impulse and certainly all stealing has to do with self-control. The importance of biology or the internal environment in self-control has been pointed out (Goldfried, 1971; Luthe, 1970). There is indeed a complex relationship between the Central Nervous System (CNS) and the Autonomic Nervous System (ANS). Wadsworth (1976) has linked the interaction of these nervous systems to delinquency and concludes that criminal behavior in males may be associated with abnormal autonomic functioning. This functioning, Wadsworth feels, may indicate a state of chronic over-arousal. A direct relationship between arousal level and amount of stealing by halloween trick or treaters has been reported (Diener, Westford, Diener & Beaman, 1973) and Millman, Schaefer and Cohen (1977) suggest that furtive stealers are less bold and courageous than their more open and aggressive counterparts. Perhaps furtive and aggressive stealers differ on some constitutional factors relating to threat sensitivity or perception of risk.

Electroencephalograph recordings (EEG) offer even more specific differences between thieves and others. There are EEG characteristics peculiar to stealers and these tracings may have predictive validity! Estimates of EEG irregularties among prisoners are higher than would be expected among the general population (Silverman, 1944; Hill & Pond, 1952). In studying 100 delinquent males, 90% of which had committed theft, Forssman and Frey (1953) found lower alpha frequencies in their EEG tracings when compared to a control group.

Since most studies of EEG differences in criminals versus others have used already incarcerated subjects, the question of whether or not these abnormal tracings existed before the criminal behavior and incarceration has not been well addressed. Do EEG tracings have predictive validity for later delinquent behavior—theft in particular?

In a previous study (cited in Petersen, Matousek, Mednick, Volavka, and Pollock, 1982) Mednick, et al noted that the presence of slow alpha brain wave tracings predicted delinquent behavior (especially thievery) ascertained six years later! Later that same year Petersen et al (1982) did a similar study investigating the power of abnormal EEG tracings to predict later stealing behavior. There were 571 EEG recordings of subjects from 1 to 15 years of age. Subjects had to meet extremely rigid criteria before inclusion for study so the possibility of a deviant EEG representing gross central nervous system functioning attributable to specific organic conditions could be ruled out. These criteria suggested these subjects to be highly "normal". Persons with a history of delinquency or criminality at the time of EEG were also not included. Thus, the sample represents a group at relatively low risk for delinquency. Their results clearly suggest that the EEG slowing (slower alpha) precedes at least one type of criminal behavior--thievery. Visual examinations of the EEG recordings indicated significantly lower alpha frequencies among thieves. Quantitative analysis indicated alpha 1/alpha 2 ratios significantly higher among thieves which again implies slow alpha. Lower age ratios, implying "immaturity" or "slight abnormality" were also obtained for the stealers. This brings to mind Renshaw's (1977) biological cause for stealing--"immaturity" and may be a link to the question of how intelligence relates to delinquency.

Petersen et al points out that because of the highly select nature of their sample that the results may have been attenuated! In addition they report that slow alpha activity is not necessarily explained by maturational lag in cerebral development, deviant arousal mechanism, subclinical brain injury or genetic factors. However, these explanations may all partially, and in conjunction, play a role in the etiology of criminal behavior.

Television and Stealing

The typical broadcast day runs from approximately six a.m. to one a.m. the next day. Ninety percent of Americans own one T.V. set and 40% own two or more. The average American television is on approximately seven hours a day (Goldsen, 1977).

To say that television has an impact on our lives is an understatement. People alter their traffic patterns in the house, their eating and sleeping schedules and often split their families as some members watch one set while the rest watch a set in another room. It is a whole environment that resembles behavior modification on a massive scale reaching 71 million homes a day (Goldsen, 1977).

There are two major processes involved in the shaping of behavior as a result of viewing television. The combination of reciprocal inhibition and visual images produces imaginal desensitization. This process reduces emotional reactions to scenes (behaviors) that had originally produced anxiety and concern. Eating while watching T.V. enhances the desensitization process which erodes the feelings and emotions (guilt) that peoples' pasts have taught them to attach to certain images, symbols, behaviors, relationships, events, etc. (Goldsen, 1977).

The proven power of modeling in teaching, whether it be a specific behavior or a more subtle attitude or feeling, is a second major force in television. There have been many concerns expressed in recent years about the effects of T.V. violence on the behavior of children who watch it. Why should these effects be specific to violent behavior? It is quite likely that a child could learn about specific thievery behaviors or at least be desensitized to the idea of theft—"lots of people do it"—by seeing others on T.V. commit such acts, be reinforced and perhaps never punished. Alexander Mundy, the ex-thief on To Catch a Thief was a hero to many viewers.

The impact of television is heightened by way of its use of visual images. Human brains are organized rather consistently across subjects as to locality of areas primarily involved with certain functions. The right hemisphere of most humans is involved in the processing of music and visual images and is more closely connected to emotions than the more verbally oriented left hemisphere. Imagination and creativity are the realm of the right hemisphere. Socrates warned that stories shape the minds of children, and the philosopher, Martin Heidegger, describes thinking as metaphor. Minds are made of poesy. The power of symbols to capture imaginations through song or ballad was noted by Andrew Fletcher. "If a man were permitted to make all the ballads he need not care who should make the laws of the nation" (cited in Goldsen, 1977, p. 66).

Thus, whatever children see and hear on television relative to crime, delinquency or theft in particular will impact on their perceptions of that behavior, the reality they establish in regard to that behavior and the feelings they have about it.

Henigan (1982) examined the effects of television upon FBI crime statistics between 1951 and 1955. He found no consistent effect for T.V. and violent crime, burglary or auto theft. However, T.V. viewing was consistently related to increases in larceny. Henigan indicates that television shows at that time presented very high levels of consumption of goods in a middle to upper class life style. He believes that the effect of television viewing on larceny relates to the relative deprivation and frustration people feel as a result of such a projection of reality. Henigan does not believe that social learning of larceny by viewing it on the screen is a contributing factor. However, specific behaviors can be learned from television viewing. This author has heard of prisoners taking notes on how certain television crimes are committed and we may all know at least one child who wrecked his bicycle jumping garbage cans like Evil Knievel.

Intelligence and Delinquency: A Relationship?:

The literature reports primarily on the relationship of intelligence to the more general category of delinquency. However, Belson (1976) points out that delinquency, stealing in particular, is widespread in school age populations, especially males. Stealing is a major component of the behavior subsumed under the concept of delinquency.

Research results fall along a continuum which, although it has both extremes represented, tends to range from ambiguous to outright denials of any relationship between intelligence and crime/delinquency. Coleman (1950) reported that it was not mental deficiency *per se* but the inability to make adequate social and school adjustments that usually results in delinquency. Southerland and Cressey (cited in Austin, 1978) and others (Cavan & Ferdinand, 1975; Healy & Bromer, 1936; Merril, 1947) have indicated little or no causal relationship between intelligence and delinquency. Cowan and Ferdinand do allow that it may be related to some kinds of delinquency. A more extreme denial comes from Schafer and Knudten (1970) who, several years ago, felt that no significant relationship between low intelligence and crime or delinquency had yet been discovered. Gibbens (1968) felt that is was rather evident that low mental ability was not a significant cause of criminality. Southerland (cited in Hirschi & Hindelang, 1977) reported in 1931 that the literature firmly established no relationship between intelligence and delinquency/crime.

However, not all agree. Hirschi and Hindelang (1977) make three points in their rebuttal. They indicate that most reliable intelligence tests yield scores for delinquents approximately eight points less than non-delinquents. This yields a zero-order correlation of .38. They add that other researchers tend to argue that this correlation is due to environmental factors and then treat their speculation as fact. However, Hirschi and Hindelang cite several sources (Reiss & Rhodes, 1961; West, 1972; Wolfgang, Figlio & Sellin, 1972) in pointing out that the negative correlation between intelligence and delinquency remains intact within class and racial groups. They would argue that intelligence is related to delinquency through a set of school variables.

Austin (1981) tested this belief using a multiple indicator procedure. In this study delinquency was limited to stealing and school variables were educational zeal and teacher appeal. Teacher appeal related to how well each subject was liked by the teacher. The results indicated a positive but weak relationship between adolescent theft and intelligence (.19 to .26). However, argues Austin, teacher appeal was identified as an intervening variable, suggesting a causal sequence and thereby lending more importance to the correlation scores then their face value warrants. Thus, albeit indirectly, intelligence, in this case, is related to adolescent delinquency and theft in particular.

The evidence has vacillated as to the importance of intelligence in the process of becoming delinquent. Moore and Stephens (1974) speak of the "myth" that retarded persons are more prone to misconduct than the non-retarded. However, some recent evidence seems to favor this intuitively appealing notion but indicates it may be a very complex and indirect relationship with variables mediating between cognitive deficit and delinquency status. Material in a later section of this paper (Moral Development, Intelligence and Delinquency) would also seem to support a connection between level of cognitive ability and delinquent behavior.

Moral Development and Stealing

Morality is the development of a set of rules by which each person navigates human affairs. Ideally morality, if equally internalized, would ensure equality and equity in these interactions. Our conscience would guide us fairly.

Piaget (1948) looked at moral development from a cognitive point of view. That is, as people matured they underwent changes in the way that they thought about how and why moral dilemmas should be resolved. It is the quality of their reasoning that changes with maturity.

A more analytical viewpoint would emphasize the emotional and not the cognitive aspects of our conscience Sigmund Freud (cited in Ruma & Mosher, 1967) emphasized the feelings of guilt and self-blame which accompany the violation, or anticipate the violation of internalized standards of moral conduct. These standards come about through the process of identification with our parents and other value transmitters such as teachers, television, literature, etc.

Lawrence Kohlberg (1963) extended Piagets' work and although he has revised it somewhat since his original work the fundamental form remains the same. The theory continues to stress the basically cognitive nature of moral development but it also emphasizes the universal and invariant nature of the developmental sequence and the intrinsic organizational tendencies in thought that give rise to this sequence of changes. Kohlberg (1976) speaks of three levels of moral development with two stages at each level.

The first level is entitled preconventional. People at this level interpret the labels of good and bad in reference to physical consequences (punishment, rewards, favors, etc.) This level has two stages. Stage one people are oriented toward punishment and unquestioning deference to superior power. Stage two people think that right action consists of that which instrumentally satisfies ones own needs and occasionally the needs of others. Stage two continues to be very selfish but the beginnings of an altruistic sensitivity appear. However, this sense tends to be very basic and programmatic as in "you scratch my back and I'll scratch yours." Pragramtism and not loyalty, gratitude or justice is the core of reciprocity at this point.

The second level is called the conventional. People here are also conformists but they begin to think that maintaining the expectations of family, groups or nation has value in its own right. Not only do they conform to the social order but they begin to value the maintenance, support and justification of it. Stage three is referred to as the "good-girl-good-boy" orientation (Kohlberg, 1968). Here the person is motivated by pleasing others and seeking approval by being nice. Stage four begins a respect for authority, doing ones duty and maintaining the social order for its own sake. Fixed rules become important in moral reasoning at this stage of the second level.

Level three is the post conventional. Here the person moves toward more autonomous moral principles which have validity and application apart from authority. The emphasis at stage five reflects a social-contract orientation with a legal point of view but having the possibility of changing "laws" in terms of rational considerations of social utility. Moral reasoning here is not frozen rigidly by law and order. This is the morality of the American government, having its roots in the thinking of the authors of the constitution. Stage six is an orientation toward abstract and ethical guiding principles such as justice, the reciprocity of human rights and at the respect for the dignity of human beings as individual persons.

Kohlberg (1968) asserts that the nature of this sequence is not significantly affected by varying social, cultural or religious factors. The only thing affected is the rate of progress through the stages. Each step of development reflects better cognitive organization than the one before and each step takes into account all previous ways of thinking but offers new ways yielding a more comprehensive structure. Kohlberg (1968) asserts that children and adolescents comprehend all stages up to their own but not more than one stage beyond. In fact, he reports, they prefer the next stage.

Childhood Lying and Stealing

Peisach and Hardeman (1983) indicate a lack of empirical data to support Kohlberg's theory and that it is largely based on the study of children 10 and older. They particularly criticize its strict developmental sequence. This characteristic would suggest an inability to reason beyond one's own state of development, and therefore, a preference for views about moral dilemmas that are consistent with one's state but not beyond. However, studies have shown evidence of empathy in interpersonal relations as early as 18 months of age (Zahn-Waxler & Radke-Yarrow, 1979) and concern for others in the responses of four and five year olds (Eisenberg-Berg & Hand, 1979). Weston and Turiel (1980) report that childrens moral reasoning differs with the nature of the crime as they tend to distinguish between acts of breaking social convention or harming others.

Peisach and Hardeman (1983) studied the responses to moral dilemmas about lying and stealing of 144 first graders. Their results do not support Kohlberg's theory. Only 16% of the responses explaining why it was wrong to lie and steal could be classified as being in stage 1. Furthermore, only about 10% of the children gave such responses consistently. They reiterate Kohlberg's contention that the child progresses through the stages in an invariant sequence but point out that only 1% of the children gave stage 2 answers. Seventy-two percent of the children gave only stage 3 responses. In order to rule out the possibility that these were learned stereotypic responses with little or no depth of comprehension, the answers were screened. Approximately 33% of the answers were judged non-stereotypic, and of these, about 25% were concerned with social approval and 75% reflected concern with harming others and societal relations. In comparing lying to stealing, children appear to be like adults as they seem to perceive stealing as a more serious crime.

The concept of property rights develops slowly in children. "Mine" as a concept appears very early, before age two. "Thine" is not a concept for young, immature or retarded children. They tend to see all property as being available to them until some authority repeatedly and consistently checks their impulse to take whatever they want (Renshaw, 1977).

Moral Judgment, Stealing and Sex of Subject

Kohlberg (1969) argues that girls achieve "good-girl" (Stage 3) morality earlier and persist in it longer than boys. However, once again, there are conflicting results in the literature. Saltzstein, Diamond and Belenky (1972) in studying moral judgment and conformity found girls overrepresented at stage 3 in comparison to boys (50% versus 8% of their sample). Boys were more representative at the lower and higher stages of moral development. On the other hand, Peisach and Hardeman (1983) found no sex differences in investigating moral reasoning relative to lying and stealing with first graders.

Wright and Kirmani (1977) report that more males than females self-report shoplifting (62% to 43%), and Hampton (1975) indicates that the rate for female shoplifting is internationally lower than for males.

Although agreement is not total, there is some support for the idea that girls and boys have a somewhat different passage through their moral development. Most importantly, however, boys appear to be more involved in theft than girls. This is certainly consistent with the age old stereotype of boys being "in trouble" more than girls.

Moral Judgment and Conformity

Moral issues and judgment are factors related to the decision to conform or remain independent in a social influence situation. Often, when discussing this yielding to social pressure, conformity is equated with immorality or at least as not equaling morality. However, Durkheim (cited in Saltzstein, Diamond and Belenky, 1972) indicates conformity may be a matter of moral obligations and duty. Deutsch and Gerard (cited in Saltzstein, Diamond and Belenky, 1972) and Jackson and Saltzstein (cited in Saltzstein, Diamond and Belenky, 1972) have shown that conformity is greatest when there is some positive interdependency among group members. That is, when a goal couldn't be reached without the cooperative effort of group members. The stealing of gangs comes to mind here.

Saltzstein, Diamond and Belenky (1972) investigated the relationship between moral judgment and conformity of seventh graders in a group pressure situation. Overall, they report conformity was clearly related to moral judgment. However, those at the highest moral judgment levels conformed least and those at stage 3 (good-boy--good-girl) conformed most. At this stage, need and morality are distinguished, but feelings and need for approval are not differentiated from right and wrong. This approval seeking state predisposes the subject to feel obligated and, thus, conform in an effort to obtain acceptance.

Moral Judgment and Guilt

Piaget focused on the cognitive aspects of morality, while Freud emphasized the emotional (guilt). Thus, Ruma and Mosher (1967) hypothesized that there should be a positive correlation between level of moral reasoning and level of guilt experienced for transgressions of moral standards. They studied 36 male adolescents, 15-17 years of age who had been adjudicated delinquent—mostly (75%) for theft. They compared the responses to Kohlberg's Moral Judgment Interview, and three measures of guilt. They found that moral judgment is positively related to guilt over transgression in delinquent boys.

This is contrary to the often held opinion that antisocial or delinquent persons do not suffer guilt for their moral transgressions. Even among those delinquents with an unmitigatedly tough "acting out" there is evidence of guilt proneness. This tendency is sufficient enough to include factor 0 (guilt proneness) of the 16 PF in the specification equation for predicting delinquency (Cattell, Eber & Tatsuoka, 1970). This author has seen many adolescents who are breaking numerous rules of parents and society (16 PF = G-) but who pay for it with considerable guilt and apprehension (16 PF = O+). This pattern is common amongst rebellious adolescents (Karson & O'Dell, 1976).

Thus, level of moral judgment is positively related to the feelings of guilt a subject has following a moral transgression and there is clear evidence of guilt proneness in acting-out delinquents. This would suggest some motivation to stop the behavior that produces the guilt, anxiety, apprehension, etc. Henderson (1981) believes most young thieves are adamant that they want to stop and reports having met only one thief in seven years of clinical practice who did not. However, not all stealers will report a desire to stop. The forces motivating and reinforcing their stealing may be stronger than the guilt pains that follow. If the stealing is thought to be symbolic, perhaps disguised anger at parents for perceived rejection, the therapist should try to explore this issue in depth while also pointing out the vicious circular behavior the student is involved in. That is, perceived rejections—anger—indirect expressions (steal) in trouble-more rejection, etc. It is much easier to change behavior than to change the level of guilt one experiences after certain behaviors (Karson & O'Dell, 1976).

Moral Development, Intelligence and Delinquency

Kohlberg (1963) argues that moral reasoning is not only primarily a cognitive process but that its development is closely related to the evaluation of logical operations—intelligence. Piaget (1977) and Kohlberg (1976) report that younger children tend to focus on external consequences (level I) when responding to moral dilemmas while older children consider other aspects in a stealing situation, such as feelings of the owner. Jackson and Haines (1982) studied 48 retarded and 48 non-retarded subjects responses to moral dilemmas. The subjects were matched on the basis of mental age but not chronological age. Thus, the non-retarded were younger. The results indicated that 12 to 14 year old "retardates" respond like 6 to 7 year olds to situations involving moral judgments and impulse control. These data suggests a definite developmental phenomenon and the authors feel that a retarded 14 year old apprehended for stealing should be viewed rather like a six or seven year old child.

Thus, there seems to be support for the contention that moral development and intelligence are related. Furthermore, although weak, there is some support for the connection between intelligence and delinquency. Therefore, a positive relationship between moral development and delinquency might be anticipated. Indeed, several authors (Eisikovtis & Sagi, 1982; Ruman & Mosher, 1967) indicate the moral judgment of delinquents is lower than of non-delinquents. However, as often is the case, not all agree. Elmer, Heather and Winton (1978) investigated the possibility that delinquent tendencies were attributable to either cognitive immaturity (retardation) or to relative immaturity of moral reasoning. They concluded that there was little support for an association of delinquency and intelligence and no firm evidence of a correlation between moral reasoning level and self-reported delinquency. They feel, as Peisach and Hardeman (1983) that their results raise some questions about the adequacy of Kohlberg's theory as an account of moral socialization.

Moral Development: Family Impact

One's values come about largely through the process of identification with parents and significant others. The influence of peers, literature, and the media must also be considered, but the exact nature of this handing down of values is not known. Some charateristics of families of stealers have been documented, and there is a literature relative to parent management and moral development.

Loeber, Weissman and Reid (1983) compared the family interaction patterns of assaultive adolescents, stealers, and non-delinquents. They found stealers second on the continuum of aggressiveness behind assaultive, but more coercive than non-delinquents. This is supported by other researchers also (Patterson, 1982; Reid & Hendricks, 1972). However, although stealers were more coercive than non-delinquents, their parents tend to reciprocate less the coercive behavior of their sons and are more non-opposing and distant than parents of both aggressive and non-delinquents. The stealers and their mothers demonstrated lower rates of positive and negative social interaction when compared to oppositional but non-stealer families (Reid & Hendricks, 1973). Furthermore, Patterson (cited in Reid, River & Lorber, 1980) found mothers of social aggressors and mothers of stealers to differ on their MMPI profiles. The former peaked on D and Hy while the latter group showed maximum scores on Pd and Ma.

Thus, stealers show more coercive behavior than non-stealers and family members seem less cohesive and more distant from one another. Mothers of stealers in particular are less intensively engaged with their children and are less anxious and more sociopathic than the mothers of social aggressors. The importance of such sociopathic trends relative to the intrinsic value of parental antecedents in the development of moral behavior is underscored by Johnson's (1949) concept of super ego lacunae. That is, some parents find gratification in the delinquent behavior of their children and unconsciously foster its continuance. This may be very subtle, as a slight smile and a comment on how clever a theft was or it maybe more open and direct. It is parental pathology acted out by and through the child. The parent obtains vicarious pleasure from the child's stealing (Renshaw, 1977) although there may be a "show" of discipline. Parents of stealers also appear to have relatively poor control over their children (Reid, 1975). This makes it hard to teach them how to use immediate consequation in treating their child's stealing. Lastly, the parents of stealers, just as they seem less involved with their children, have been shown to drop out of treatment more often than families of social aggressors (Holleran, 1981) and to often require therapy for marital problems and other conflicts in the home beyond the child's stealing (Phillips, 1981).

Modeling, of course, plays an important role in learning many behaviors. Association with other stealers, especially if family members, has a significant impact on learning and exhibiting such behavior. In fact, being aware that parents steal has more impact than awareness of peer stealing (Dituri, 1977). Dituri found that 10 year olds view adult lying and stealing as worse than the same behavior by peers. Thus, the behavior is underscored and the lesson heightened. The desensitization to stealing is greater if a child has seen or is aware that the parent does it. Parents are linked to authority and if the parent is a thief, at least some authority figures steal.

There is evidence indicating that the moral development of the child is linked closely to that of the parents—especially the mother. In a study of 53 "normal middle class families" with eighth graders, mothers who used higher stages of moral reasoning had children who employed higher stages. In addition, in those families with "parental conflict" the moral level of the mother and child was correlated more highly even if the father's moral level was higher (Holstein, 1972). Hudgins and Prentice (1973) assessed the moral development of mothers with non-delinquents and mothers and delinquents. In both cases, the parents had higher levels than their children but the mothers of non-delinquents were higher than the other mothers, and the non-delinquent kids used higher levels than the delinquents.

Disciplinary style has also been linked to level of moral development. Hoffman (1977) describes three styles: assertion of power, withdrawal of love and induction. The first threatens the child and he/she fears a punitive reaction by the parent. The child's focus is on the consequences to the self. Thus, the child perceives moral standards to be external and learns behavior controls based on threat and fear. A threatened loss of love uses emotional elements such as fear and anxiety. A child's compliance to this style is again self-centered and because of external forces. However, induction, the explaining of the "why" part of the "shoulds" and "oughts" emphasizes possible consequences of behavior. This makes the child aware of the relationship of his/her behavior to others. This knowing how his/her behavior contributes to the distress of another aids the development of guilt feelings which are an internal source of moral guidance.

Miller and Swanson (cited in Eisikovits and Sagi, 1982) found a positive relationship between induction and ability to resist temptation in adolescent boys. Katovsky (1967) reported that internal control and induction were positively related, while Hoffman and Saltzstein (1967) found that induction methods related positively to higher moral development. Using a number of different measures of moral development, Eisikovits and Sagi (1982) studied the impact of an inductive parental style of discipline on the morality of delinquent and non-delinquent adolescents. They found less induction with delinquents and a positive relationship between induction and most moral measures.

A number of other authors (Craig & Glick, 1963; Hirshi, 1969; West & Farrington, 1980) have also found a positive correlation between parental management approach and delinquency. Thus, at least indirectly, "how" parents raise their children could increase their risk for stealing behavior or more appropriately, help them resist it despite external forces.

Assessment: A Stealing Personality?

Bradford and Balmecado (1983) indicate shoplifting is not a specific psychiatric syndrome but psychiatric illness is clearly a factor in the shoplifting behavior of certain female adults. Several authors report depression as the most common psychological disorder seen in adult shoplifters (Gibbens, Palmer & Prince, 1971; Gibbens & Prince, 1962; Medlicott, 1968). Edwards and Roundtree (1981) describe low ego strength in a sample of shoplifters and yet MacDonald and Paitich (1981) found high ego strength for 71 thieves (16PF = C+). They used IQ, MMPI, 16PF, Rohrsach and Parent-Child Questionnaires with 71 thieves, 24 unemployed controls, and 42 assaulters. The results discriminated between groups "poorly". They concluded that there was no outstanding thief profile. Reid, Rivero and Lorber (1980) describe stealing as behind the back aggression. Achenbach (cited in Reid, Rivero & Lorber, 1980) and Hewitt and Jenkins (1946) found different factor structures for stealers versus fire-setters. The former were more covert in their acting out versus the more open and socially aggressive fire-setters. Thus, personality test responses suggesting a tendency for furtive rebellion might predict stealing. Furthermore, test results indicating reduced trust may have predictive value for females. Several authors have found low-trusters to be less trustworthy than high trusters (Geller, 1978; Hamsher, 1969; Rotter, 1971; Wright, 1972). This is even more interesting if the concept of projection is considered. Wright and Kirmani (1977) found that male high and low trusters did not differ in amount of self-reported shoplifting but females did. Low trusting females were more likely to report shoplifting than high trusting females.

Risk taking is also related to adolescent theft, i.e., shoplifting. Adolescents that shoplift are more willing to take risks than non-shoplifting adolescents (Applebaum & Klemmer, 1973). Three to eleven year old boys are more likely to take risks than equal age girls and age and risk taking increase together (Ginsurg, 1982). Norms for the 16 PF would also suggest males to be more risk taking (H+) then females and yet Arenson (1978) reports no sex difference in risk taking among 112 male and female subjects.

Fishburn (1982) has shown that every prospect that has no perceived chance of loss has no perceived risk. Therefore, any student with an over inflated sense of adequacy or feelings of omnipotence may be more likely to steal as he/she will under-judge the risk. Indeed Belson (1976) cites the belief in the improbability of getting caught as a causal hypothesis.

Thus, personality evaluation may be of some help in assessing whether or not one is a thief. However, there is no particular personality profile for stealers. Stealing is a behavior that can be accompanied by a variety of other characteristics unrelated to the stealing itself. It would be far more productive to simply ask the student, his parents or teachers. Parent reported stealing events were highly predictive of later delinquent status (Moore, Chamberlin & Mukai, 1979). In fact, in view of the predictive value of past stealing for future legal and adjustment problems it may be wise to routinely investigate this possibility. A good social history may also be helpful as a transitive progression from poor peer relations to wandering, to lying, to stealing and then fire-setting has been shown by Patterson (cited in Reid, Rivero & Lorber, 1980).

Digging into the details of the child's stealing and his family's thinking about it and reaction to it may help the school psychologist understand different variables that promote or maintain such behavior. For instance, one or both parents may have a history of stealing, or convey an attitude that the world "owes them" because of some perceived misfortune, thus rationalizing theft. In such cases one expects the conscience of the children to have some gaps, as stealing, keeping something found, taking a little extra, etc., will likely be subtly or directly reinforced by the parents. There may also be some very obvious reinforcing consequences beyond the stolen item. The child may receive a great deal of attention from otherwise cool and distant parents or peers they wish to impress, etc.

By and large however, assessment consists of catching the child stealing or being told by a reliable informant, including parents, teachers or the child. The self-report approach has been criticized (Hood and Sparks, 1970; Nettler, 1974) as being of questionable validity. However, Hardt (1977) found a high level of validity in data collected by self-report. Although there are concerns with this technique it is the only alternative to relying on inadequate store records. The degree to which any clients life seems to fit into the different sociological considerations would also be helpful in raising the potential for stealing behavior. However, self-report, other report or being caught are the best sources of information.

Kleptomania

Kleptomania is considered to be a rare and special kind of stealing which, on the surface, appears to be irrational as it seems to be theft without gain. Early accounts allude to bizarre and worthless thefts by the rich and higher social class including Henry IV of France (Gibbens and Prince, 1962).

Pinel and Esquirol (cited in Bradford & Balmecado, 1983) formulated the concept of "instinctive impulses" and described the "instinctive monomanias." They originally included alcoholism, firesetting and homicide. Theft was later included in this list of impulse problems and in 1838, Marc (cited in Bradford & Balmecado, 1983) first described kleptomania. Fenichel (1945) refers to kleptomania as an impulse neurosis and the Diagnostic and Statistical Manual of Mental Disorders (3rd edition) lists kleptomania under Disorders of Impulse Control. Diagnostic criteria are that the theft be impulsive, preceded by tension and yielding a release of tension at the time of the theft. Objects are not taken for monetary gain or immediate use. They are often given away, returned secretly or kept and hidden.

Although, Kahn and Martin (1977) reported that kleptomania may possibly be related to cortical atrophy, there appears to be little suggestion in the literature that kleptomania may have physiological underpinnings.

The incidence of kleptomania is very low (Gibbens and Prince, 1962; Keutzer, 1972). In fact, some believe that no clear entity exists (Gibbens & Prince, 1962). Arief and Bowie (1947) considered only 3.8% of their population of shoplifters to be kleptomaniacs, Bradford and Balmecado (1983) found approximately 4% of their sample qualified but Medlicott (1968) found 8% to be kleptomaniacs.

Traditionally, kleptomania has been considered a symptom of underlying conflict or mental illness (Gibbens & Prince, 1962; Fenichel, 1945; Keutzer, 1972). "True" cases of kleptomania are considered to be rare (Keutzer, 1972; Russell, 1973). Keutzer (1972) believes there is such an entity and defines it as being distinguishable from rational, aggressive social or psychopathic stealing. He also believes it is irresistible and repetitious stealing which is impulsive and followed by a reduction of anxiety. Both Keutzer (1972) and Fenichel (1945) feel kleptomania is a "morbid" impulse to steal with roots in childhood sexuality. Fenichel (1945) believes it originates in "erotic fixations" which produce psychic conflicts first manifest in struggles with masturbation and subsequently replaced by a "morbid" craving to steal. In a similar clinical vein Hinsie & Campbell (1960) suggest such thievery to symbolize a claiming of affection that has been withheld or a definite repressed wish often associated with penis envy. Another author (Student, 1981) felt that the stealing of five female kleptomaniacs he treated was a substitute for open aggression against their husbands. It was to release accumulated tension and symbolically punish their partners.

Treatment of Kleptomania

In view of the rarity of this phenomenon, at least in a more sure form, it is doubtful if many school psychologists should concern themselves with these considerations. In fact, except for Keutzer (1972) and Fernichel (1945) alluding to childhood origins the literature presently reviewed did not speak of kleptomania with children.

Nevertheless, one article reviewed was impressive and bears recounting. This treatment approach could be easily modified to accompany many problems of impulse given enough subject motivation. Homme (cited in Keutzer, 1972) argues that thoughts are subject to the laws of conditions just as any observable behavior. People are subject to the laws of nature--including reinforcement theory. Thus, because a person can reliably detect his/her own thoughts and self-administer a particular consequence he/she can eliminate impulses to steal with a punishment condition paradigm. Keutzer (1972) describes such an approach with a woman who was stealing approximately $196.00 of merchandise a week during base line. He used breath holding as an aversive consequence by having the patient hold her breath each time she noticed an impulse to steal. By the first week she was down to $20.00 of merchandise a week and finally zero. A ten week follow-up revealed no return toward base line. Keutzer considers the possibility that the breath holding itself may have become the substitute symptom.

Treatment of Stealing

Some authors feel that programs for reducing theft have been rare and ineffective (Azrin & Wesoloski, 1984). On the other hand, after treating approximately 500 children reported for shoplifting, the Scott County Iowa Juvenile Diversion Program reports a 94.5% success rate. The treatment of stealing has taken a variety of approaches. Legal, biological, behavioral, cognitive, individual, group and family paradigms will be described.

Legal

The Juvenile Court in Scott County, Iowa operates from a two prong philosophy. It strives not only to work in the best interests of the child but also to protect the interests of the community. Thus, after the first offense, juvenile shoplifters are referred to the Juvenile Diversion Program for Shoplifters. This is viewed as a consequence in the best interest of the child. After the second incident the court will be working to protect the interests of the community.

After a complaint alleging fifth degree theft (shoplifting) has been lodged the shoplifting program administrator checks to see if the child has been through the program before. If so, the referring agency is told that the child cannot attend again and they are encouraged to refer the child to Juvenile Court for prosecution. If the child is a first time offender and admits their guilt, a letter is sent to the parents notifying them of the time, date and place of the next scheduled shoplifting program. The program is held once a month, is two hours in length and must be attended by the child and at least one parent for successful completion. If not successfully completed the child is referred to Juvenile Court for prosecution.

Prior to each program, the police department, probation office and local merchants are contacted to secure a guest speaker from each group. There is a rotating list of guest speakers.

The program begins with the film "The Myths of Shoplifting" which exposes some invalid ideas many offenders have about shoplifting. They are: (1) shoplifting doesn't hurt anyone, (2) no one gets caught, (3) if you would be caught, nothing will happen, (4) no one gets arrested for shoplifting, (5) convictions don't stay on your record past 18 years of age, and (6) once it's over--it's over for good.

The presentations by the speakers are educational and try to get the offender to realize the perspective of the group represented by each speaker. The merchant may speak of some general shoplifting statistics and explain, using several commonly stolen items from their own store, how much their cost is, how little their profit is and the impact of each stolen item in terms of expense passed on to the consumer. The offenders are educated as to the prevailing attitudes and corrective measures taken by more and more merchants. That is, all offenders will be prosecuted and increasing efforts are being made to make shoplifting easier to detect, i.e., store layout, cameras, mirrors, etc.

The police officer, who also volunteers his/her time attempts to convey, via statistics and warnings, how serious shoplifting is and the potential for continued legal involvement.

Then the speaker from the Juvenile Court gives additional information about the cost of prosecution, which is passed on to taxpayers and step by step details of being processed through the system. The offenders are told how many referrals for shoplifting have been received so far that year, that in Scott County, handling of each case (excluding court costs) costs about 94.00 dollars and that legal action is taken after the first incident. There is no more waiting until the second or third offense. The following is an outline of how an offender would proceed through the system in Scott County, Iowa:

1. Allegation of a criminal offense being committed
2. Intake Interview
    a. can dismiss
    b. can reprimand and release
    c. refer to: Social Services, Psychiatric treatment, or Emergency Medical care
    d. informal adjustment (1-6 months informal probation)
    e. community service work
    f. process the child for court proceedings.

3. Detention Hearing (arraignment)
    a. proceedings to determine whether a minor should be released to parents or held in facilities of differing levels of restraint.
    b. probable cause must be determined that the child committed the crime.
    c. detention hearing can result in: release to parents, dismissal of charge, secure detention, or In-Home detention.
    d. Adjudicatory Hearing is set. Social investigation is conducted.

4. Waiver to Adult Court
    a. can be waived to adult court if 14 years of age or older.
    b. if the child's record is lengthy.
    c. Juvenile Court has exhausted its rehabilitative resources for the child.

5. Adjudicatory Hearing
    a. the child's trial to determine whether the charges are proven.
    b. if proven, adjudicated to be a delinquent child. If found not to have committed the act, dismissed.

6. Disposition Hearing (outcome)
    a. order assigning minor to the appropriate program for rehabilitation
    b. result can be: Commitment to the Iowa State Training school, probation or Mental Health Institute.
    c. Records: Juvenile's records (convictions) are not "erased" at age 18.

After all this is shared with the offenders and their parents they are encouraged to discuss their feelings about the information and their recent shoplifting incident. That is, how has it affected them, their family, how people trust them, etc. In conclusion, participants must complete a program evaluation form.

From October 1981 to June, 1984, 472 offenders have gone through the program. There has been a 5.5% recidivism rate (26 children) and a 94.5% success rate (446 children have not been reported for shoplifting again)! This is commendable particularly since a juvenile's chances of re-offending are significantly increased by a first court appearance (Department of Social Welfare, 1973).

Biological/Behavioral

In a 1981 article, John Henderson described a rather comprehensive approach to the treatment of stealing in youth. The only necessary prerequisite is that the clients "want" to stop stealing. Hendersen believes that this is almost always the case!

Hendersen's program is referred to as Individualized Combined Treatment (ICT) because it attends to both the internal and external environment of each client. It can be conceptualized in three broad areas: self-control of the internal environment; adult or responsible other control of the external environment; and personalizing the program by the psychologist.

Self-control of the internal environment is taught so the client can have a chain of responses having an end response which is not stealing but which was triggered by the stimuli formerly discriminative for stealing. Biofeedback (heart rate) and relaxation of muscular contrast are used to teach the client to generate internal signal stimuli different from those associated with stealing.

Relaxation training is taught for several reasons. The aim is to achieve a lower level of general arousal as this is positively correlated with theft (see Biological Factors under Etiology), to aid in becoming aware of and changing internal stimuli, to facilitate relaxation versus action in response to stimuli previously discriminant for theft and to reduce psychosomatic reactions. Selye (1965) his reported that thieves often have a number of such symptoms because of the stress they suffer relative to anxiety and guilt about stealing. Relaxation is also claimed to help restore balance in the autonomic nervous system (ANS). Imbalance in the ANS has been hypothetically linked to behavior disorders (Porges, 1976). The biofeedback reduction of heart rate is used to augment the relaxation response.

During relaxation training the client is asked to imagine himself in a setting discriminative for stealing and is instructed to "Stop, relax and walk away." The client signals his imagination of the scene by raising his finger and then drops it as he "views" himself walking away. This is immediately reinforced by the therapist who delivers verbal praise. The client is gradually expected to practice this imaginal strategy outside the clinic and ultimately put it into practice in real potential theft situations. The client is instructed to "talk to himself" as a thought-stopping and response redirecting device. Michenbaum and Goodman (1971) have shown that childrens control of motor responses is facilitated by such self-talk.

In ICT the client is sensitized to both internal and external stimuli liable to be discriminative for stealing and is taught to talk himself out of it. In some cases the practice of self-control is partly externalized by an adult leaving traps for the child with his/her knowledge. The child is given bonuses on a token system for not taking the traps which are gradually made less obvious and easier to take without being caught.

Control of the external environment focuses on reinforcing "not stealing", a practice not endorsed by all therapists who treat stealers (Reid, 1975). This is accomplished with a rather complex system wherein the child is judged to not have had time to steal since the time it takes to get from one supervised area to the next has been measured and his travels throughout the day are recorded. Travels and time frames are recorded in a notebook kept by the child. Daily computation of time "not-stealing" is computed and ensures daily reinforcement for total number of minutes each day that the child did not steal.

Individualization of reinforcers is done by finding out what the child did with the goods he used to steal and providing the same or better consequation for "not stealing".

Henderson (1981) reports his success with ten cases using ICT. Clients were 8 to 15 years of age at the onset of treatment and had been stealing for 6 months to 8 years with frequencies of "infrequent" to more than once a week. The value of stolen items ranged from one dollar to more than 10 dollars per theft. Follow-up was done from 2 1/2 to 5 years after ICT began. During this time, two of the ten clients re-offended. One stole after 18 months of not stealing, and the other stole twice, 3 months and 12 months after treatment began. Both of these individuals started treatment with a 6 1/2 year history of worsening theft. At the time of the article publication, Henderson reports both of these re-offenders were close to two years of not stealing. Overall, 80% of the clients stopped stealing after treatment by ICT and have not stolen again as of the date of the report (1981).

ICT is impressive in its comprehensiveness and intuitive appeal, but may be difficult for the average school psychologist to implement. The control of the external environment as described would suggest a great deal of effort and commitment on the part of the parents as well as the child—a rare combination. Previous analyses of dropouts from family treatment programs for conduct disorder kids has shown that the families of those kids who also had stealing problems were most likely to drop out of treatment (Holleran, 1981).

Behavioral

The following are some general guidelines for any behavioral approach to the treatment of stealing plus highlights from a number of specific behaviorally oriented interventions.

Behavioral techniques require control of response contingencies and work best in very structured/monitored environments. Wetzel (1966) points out it is better to remove reinforcers that maintain a behavior, to differentially reinforce other, more appropriate behavior (DRO schedule) and to avoid punishment. Bandura (cited in Wetzel, 1966) has indicated that punishment is used when the consequences of behavior are unknown or uncontrollable. It can't be used in some places (schools) and has anger and resentment as side effects. Removal of positive reinforcers is not as aversive, often more natural and can be used when maintaining consequences are unknown. Subjects must be aware of how their behavior relates to consequation. James and Rotter (cited in Wetzel, 1966) have pointed out how the reinforcing value of a stimulus is a function of whether the subject perceives his getting it as related to chance or his own behavior. However, the more natural the environment the more likely that there are multiple reinforcers maintaining the stealing behavior. The objective recording of behavior is essential and those involved must be patient as any treatment will yield variations in response rates. If several people are involved in recording behavior, the operational definition of the target behavior must be clear and discriminative. Sometimes, people responsible for recording the theft of a child are reluctant to do so as they view it as a criminal record and feel they are being too harsh. All involved must be consistent in recording and consequating.

From a behavioral point of view it is easy to see why stealing is hard to treat. It is a low frequency behavior that is hard to observe and self-reinforcing. There is often a delay between the behavior and the consequence arranged to control it yet it is reinforced immediately. Furthermore, there is often a problem of valid information or proof.

The following highlights of a variety of behavioral approaches to stealing will be designated by certain behavioral and subject characteristics so the reader can find the treatment of relevance to his/her own situation.

Correction/overcorrection/Low intelligence

Azrin and Wesolowski (1974) significantly reduced theft by retarded adults using correction and overcorrection procedures. The target behavior was theft of food at lunchtime and the treatment approaches were compared as to effectiveness. One group simply had to return the food when caught while the other had to give the victim an additional and equal item of food as well. The correction approach yielded a maintenance of base line while the overcorrection led to "total elimination" by the fourth day. The authors believe overcorrection is a better technique because by returning the stolen item the positive reinforcement, in many cases, is undone and the effort to return an equal item is aversive/punishing. In addition, the time taken to do all this was time away from lunch (time out) which was also aversive. On a more positive note, returning the stolen item was positive and "re-educative." The authors feel this procedure is good for young children as well as they are also easy to catch.

Time Out

In a similar vein Barton, Garcia and Baer (1970) used a straight forward time away from meal approach for older retarded people caught stealing food. They reported a 57% reduction in such thefts.

Personal Time as a Reinforcer

Wetzel (1966) describes the case of a 10 year old who stole items at a group home and at school and gave them away as if buying attention/affection. Treatment capitalized on the need for attention. The cook at the home was attractive to the boy and participated in treatment by beginning a relationship with him. She even took him to visit her home. When treatment began however she was informed of any thefts and on those days, when he approached her, she would explain she couldn't see him because he had stolen. The explanation was matter-of-fact and calm-devoid of anger but inductive. In addition, the staff praised him for periods of non-stealing (DRO). Wetzel (1966) reports a drastic reduction in stealing and an improvement in peer contacts after four months. He reports a brief period of pants wetting as symptom substitution.

Group Contingency/Stealer Unknown/Class Lecture

In this study, an entire second grade class received rewards or punishment based on the stealing behavior of the class regardless of the number of guilty pupils (Switzer, Deal and Baily, 1977). During base line, the number of pencils, toys, erasers, etc., stolen or returned were counted for 90 minutes each morning for two weeks. Then two of three classes received an anti-stealing lecture. Data recording continued. Each morning nothing was missing, the entire class got a 10 minute break after snack time. If something was missing the teacher would announce that he/she was leaving class for a few minutes and that the item could be returned. It was explained that if it was returned the students could talk during snack time but if not they couldn't talk and had to put their heads down for a nap afterwards.

The authors reported improvement in all three classes but those with the lecture were not significantly better. The group contingency was the significant component. They also reported no "undue" hostility or group pressure but warn that this may be a problem with older students.

Group Contingency/Stealer Known

In this study a group contingency for the behavior of one target student was arranged. The thief was a ten year old with academic and behavior problems. In addition the thefts often occurred when he would leave the group and wander off. He had been stealing a variety of items and appeared to be reinforced by negative attention from the teacher and his classmates. In addition he was trading the "hot" items for other things owned by his peers. With the target student present the teacher explained the behavior of concern to the class and how they could help him change. The thief would get one point for doing his assigned work and one point for remaining in class for a 45-minute work period or staying with the group during an out of class activity. When he had accumulated 10 points the class received a fifteen minute break to play a game or take a recess. For each point the target student failed to get the class was penalized one minute of time from their next scheduled "fun" activity. All the students were aware of these rules. In private, however, the target was told he would also be paid 10 cents for each point he earned. Brooks and Snow (1972) report that the class received free time each day the first week and that the target child was doing so well that the teacher terminated the program. Despite this rather abrupt halt the thefts stopped and did not return the rest of the year. Much attention and praise was used to maintain this appropriate behavior post group contingency.

General Public/Warning signs: General & Specific

The following study used warning signs to heighten the consciousness of potential shoplifters. McNees (1976) in attempting to help a store owner reduce shoplifting felt that many prevention programs used signs warning of the potential results of shoplifting if caught. He carried this one step further by marking specific items as being frequently stolen and therefore, in the the thief's mind, monitored more heavily. The general warning signs yielded a partial reduction but the specific signs reduced shoplifting to "near zero". Such discriminative cues might be used in a school library, the main office, or art room with attractive supplies, by a bicycle rack, in a coatroom, etc. However, the reader should also consider the following similar study.

Warning Signs: General and Specific/One Item

Thurber and Snow (1980) used the same written cues in two stores where the object was to reduce the theft of packs of cigarettes. General signs warning of the possible negative outcomes of shoplifting were placed around one store. In addition, a sign was placed at the cigarette stand indicating that these items were frequently stolen. Their results were the opposite of McNee's and they had a control store for comparison.

Despite this outcome, such warning signs continue to have intuitive appeal to this author. Such a sign may be just enough to curb an impulse or slow someone down long enough for a good controlling dose of guilt or fear to move into consciousness.

Covert Sensitization/Aversive Imaginary/Thought Stopping

Ganthier and Pellerin (1982) report their treatment of a 30 year old mother who was compulsively shoplifting items she did not need. They add she had had several arrests and convictions and reported feelings of depression and helplessness. The authors first asked the subject to try a thought stopping procedure. They did not feel this would work but wanted to see if the attention of treatment was a factor. Indeed it did not reduce but increased the thefts. Eysencks' (cited in Ganthier and Pellerin, 1982) "incubation of anxiety" theory appears to explain why thought stopping was not helpful. Shoplifting ideas yield anxiety (in most people) and short term exposure to highly anxious stimuli favors the incubation rather than the extinction of anxiety responses. The subject could not suppress the thoughts with thought stopping and so lost even more control.

The authors then treated her with Cautelas' covert sensitization technique. After relaxation training and practice in the use of mental imagery the subject was asked to imagine different shoplifting scenes as vividly as possible. These imaginary situations, directed by the therapist always concluded with her being caught and encurring a list of imaginary but most aversive consequences. Follow-up at 1, 2, 5 and 14 months yielded no re-occurrence of shoplifting.

It seems that in such an approach the school psychologist may want to be extra careful about informed consent, especially if particulary aversive imaginations were planned with young subjects.

Stimulus Control Procedure/Token Economy/ABAB Design

The subject here is a 7 year old boy with a "borderline" intelligence. He was in a structured special education class with a low student teacher ratio and an aide. He stole a variety of things from peers and teachers and would put them in his pockets, desk or "supply box." Stealing was operationally defined as having any item not marked with a green circle (his code) on him, in his desk or in his "supply box."

During base line, all of Steve's personal items were marked with a green circle and his desk, person and supply box were checked every 15 minutes. Any item found without a green circle was recorded as stolen but no feedback was given at this time. Steve was then told that he could earn points to use at the class "store" for having only items marked with green circles. Other items would result in a 5 point fine. His person, desk and supply box were checked every 15 minutes with staff providing "descriptive praise" (induction) and points after each check if all the items were his. A reprimand and a 5 point fine was given if a stolen item was found (any item not marked). This was followed by a return to base line and subsequently another treatment phase as above.

Fading occurred by maintaining the points and fines but stretching the evaluation period from 15 minutes to two hours. During follow-up all marks, points, and fines were removed but staff continued to check through Steve's possessions after a reported theft.

Base line stealing averaged 6 items per day. The first treatment phase reduced stealing to .33 items per day and the return to base line took it back to 5 items per day. The second treatment phase again reduced it to .31 and the last nine days of treatment were without a single theft. Fading lasted 12 days and yielded only 1 theft while follow-up lasted 31 days and yielded 3 thefts (.09/day).

Rosen and Rosen (1983) report that stealing was significantly reduced using a stimulus control procedure which reinforced marked item possession and punished unmarked item possession. No symptom substitution occurred and the importance of fading out a token system by reducing its salience is noted. The authors believe that tight structure, a clean operational definition of stealing and swift consequation of the target behavior were key factors in this child's improvement. They warn, however, that adult praise and reprimands are important consequences for young children but loose power with adolescents. Peer reinforcement and use of the stolen item are more powerful reinforcers with teenagers (Rosen and Rosen, 1983).

Self Control/Family Contingency Contracting

The subject here was a 12 year old black girl who was stealing heavily at school, to the point of suspension. She had exhibited "uncontrollable stealing" almost daily for 5 years, taking money and small objects at school and in stores. With the money she usually bought ice cream and candy. She was otherwise a good student with above average grades. Because of her stealing however she was given little freedom for fear her stealing would become public and the law would intervene. Stealing was the only concern and occurred 4 to 5 times per week, especially at school.

The stealing was being reinforced by immediate possession of a desired object and attention from her teacher, peers and parents. The author of this article, Jerome Stumphauzer (1976) also suspected the mother of unconsciously reinforcing the thefts as she smiled as she told about the stealing. In addition, he felt that neither home nor school provided much reinforcement for behavior incompatible with stealing.

Treatment covered 15 sessions in five months, beginning with one per week and ending with one every 4 weeks. The parents and teachers were involved first in recording base line and a physical examination assuaged the fathers suspicion that the craving for sweets related to the girls diabetes. Then the exact circumstances of previous thefts were analyzed. This included her thoughts and internal conversations. Although motivated to stop she felt she couldn't control herself. Stumphauzer (1976) had her imagine a variety of alternative objects in her environment when tempted to steal. Any one of these would be her new focus of attention and she was to self-reinforce ("I'm proud of myself") if she managed to change her focus and avoid stealing. Kanfer and Karoly (cited in Strumphauzer, 1976) felt three things were necessary for self-control: self-monitoring, self-evaluation and self-reinforcement. She had the last and by session number four began to measure her own stealing on Daily Behavior Graphs. Self-evaluation came spontaneously as in keeping a record of her stealing behavior the subject gradual shifted from simply tally mark recordings of thefts to qualitative statements about her behavior. For instance, in the beginning she would simply mark down the number of items "I stole" this week; later in treatment she recorded comments such as "I did very well, I did not steal" and "I did so well that I did not even think to steal."

In addition, simple family contracts were arranged to shift school and parental attention from stealing to non-stealing. Praise and a 20 cent allowance per day of non-stealing plus special activities and a favorite meal on Sunday as bonuses for entire weeks of not stealing were instituted.

The author reports that stealing episodes dropped from 4 or 5 per week to "two minor incidents" in the first 5 weeks of treatment. During the sixth week the rate hit zero and continued throughout treatment and follow-up at 6, 12 and 18 months.

A Cognitive Approach/Low IQ

The following treatment approach will remind the reader of Kohlbergs moral development and the concept of induction.

Jackson (cited in Haines, 1982) suggested three categories of resistance to stealing: 1) extrinsic, 2) right/wrong, and 3) intrinsic. Extrinsic resistances stems from a fear of being caught while the resistance of the "right/wrong" person reflects some notion of the incorrectness of stealing but in a rather black and white way with little depth of moral concern. The intrinsic resister has well internalized reasons for not stealing.

With this in mind, Haines (1982) attempted to train more intrinsic levels of resistance as measured by responses to temptation to steal vignettes. He compared the responses of 108 EMR (IQ 50-75) students. Some received no training, some received the general instructional program (GIP) and some a direct instructional program (DIP). This program consisted of direct instruction via, lecture, slides, paper/pencil and verbal repetition of the concepts of mine, yours, own, do not own, and stealing. He included a "Think" slide to underscore the importance of reflectivity in tempting situations and a "Be Fair" slide to stimulate some social conscience.

The results indicated a significant difference in the amount of intrinsic resistance found in the response of those students receiving the direct training. There was no difference in the general instruction group and the controls. Haines (1982) feels that the improvement was due to the embedding of intrinsic schema into memory during training. Because this is a cognitive approach and has a memory factor, such gains may diminish with time depending on each subject's memory. Haines, however, reports that at three month follow-up "many" subjects effectively stored the higher level responses in memory.

Such instruction for entire classes could be instituted after a problem with stealing or perhaps before, as a matter of routine. The literature seems to support the concept of induction with the general population and Haines has demonstrated its effectiveness with a special group as well.

Group Psychotherapy for Stealers

Ewalt, Goldmeier and Killen (cited in Edwards and Roundtree, 1981) have all offered support for a group psychotherapy approach to the treatment of stealers. Edwards and Roundtree (1981) however, would not agree. They organized six 90 minute groups with 5 to 8 people for an 8 week duration. The groups were run by trained psychotherapists with similar backgrounds who had weekly consultation and videotape review with a psychiatrist. These appear to have been interpersonal awareness groups as members received personality information and learned communication skills. Vehicles were Reality Therapy, Transactional Analysis, Parent Effectiveness Training, Gestalt Behavior Modification and Assertiveness Training. The insight and ego strength or better personality integration that can often follow involvement in the group process was the apparent goal. This, of course, was hypothesized to then reflect itself in reduced stealing as impulse control would be better and psychological problems that may have motivated theft would be improved.

The MMPI ego strength scale was used as a dependent measure and only profiles with an F-K index within ±9 were accepted. In comparing a group of stealers arrested and treated with a group only arrested they report no difference. Both groups yielded low ego strength scores. They felt this indicated a lack of treatment effect and underscored the low ego strength and self-centeredness of the shoplifter or "generic lawbreaker."

Classroom Techniques

A recent issue of Yesterdays Puzzle, a printed consultation service for teachers (author and date unknown) suggested the following approach for teachers with stealers. The need for "incontrovertible" proof, prior to consequation is stressed and the fact that this low-rate behavior can't be treated as other common but high-rate behaviors is noted.

The author suggests a private conference with the alleged thief indicating the teachers concerns about others thinking he is stealing, that stealing is wrong and that it could get him into serious trouble. Do this privately, humiliation is counter-productive. Secondly the thief is told they may have in their possession only the necessary school supplies and that the identity of these items will be remembered (coded ala Rosen and Rosen, 1983). The student is told that anything else found in his possession after rule implementation will be considered stolen.

The third step is to establish a routine whereby the teacher gives the target student the opportunity to be checked about stealing when he is innocent. The teacher wants to test the student early and often when they can truthfully admit no guilt. But the student's verbal response alone is not sufficient. The teacher must explain a need to be sure so that a theft is not unwittingly reinforced. Pockets and desk contents are to be inspected. Such verification should be frequent early on but faded to an intermittent schedule as treatment progresses. Verification should be in private and the non-verbal tone is to convey the importance of proving trustworthiness and not the teacher's anger or feelings of being burdened. Honest answers must receive praise and all dealings should be calm and respectful.

When a stealing event does occur, serious consequences must ensue. He must return the object, he is not permitted to play or eat with the others that day, he must stay continually in the teacher's non-reinforcing company, he must write a note of explanation and have his parents sign it and, if a token system is in effect, he must loose a large amount.

The above represents a nice collection of behaviorally sound techniques woven together to yield an intuitively appealing approach. Correction, time out, supervision, punishment, response costs, positive reinforcement, shaping and fading procedures are involved.

Some additional suggestions for teachers are offered by Mack (1978):

Finders Box - a box where items can be placed anonymously. Students may put in items they've found or stolen and now want to return anonymously.

Retrieving Whats Visible - the teacher may avoid an incident when she sees one students ink pen (or hers) sticking out of anothers pocket by simply grabbing it and commenting "Oh you've found my pen, I've been looking all over for it." However, such avoidance of a scene may be perceived as tacit approval or at least non-concern for the stealing.

What's Missing Announcement - the teacher announces "we'd like to have ______ returned to my desk by the end of the day--no questions asked."

Lecture Approach - offer a firm but friendly warning about stealing.

The Chance to Talk - The teacher tells the class that "I'll be in class during recess and after school if anyone wants to talk with me about this (theft).

> Role Play - have the students role play various situations involving theft but leaving the stories unfinished. The group discusses possible endings.
>
> Thinking In Writing - have the students write a composition discussing why kids steal, how it feels to be stolen from and how it should be handled at school.
>
> Loan Sharp - for students who borrow but don't return items, send them outrageous reminder notes such as "If you don't return my pen a large rubber band will zap you back to my desk."

Last Resorts

The teacher could announce that no one goes home until the missing item appears. The students are responsible for explaining to their parents why they are late. This authors feels such an approach would penalize too many innocents whose parents may not be so understanding.

An alternate action would be to inform the students you are going to search pockets and desks. After one search they will know you are serious and often the item quickly appears before all the desks have been searched!

Parental Involvement in Treating Stealing

The National Retail Merchants Association (cited in Weinstein, 1974) offers some general guidelines for parents:

Be sure your child is aware that stealing (shoplifting) is a crime which can yield a lifelong record.

Be aware of the money your children have and how they spend it. Know where their possessions came from and don't hesitate to check with other parents.

Discourage "hanging" around shopping centers or department stores.

Stress the lesson that succumbing to peer pressure is a weaker response than self-control.

Nuture their conscious by your own example and if your child steals provide consequences. Do not allow it to pass uncorrected.

Comer (1980), Salk (1972), Driekurs (1964) and Renshaw (1977) have stressed that the parental reaction is crucial. They must respond and not deny or cover up the situation, since such a casual response invites recurrency as condoning is implied. However, it needs to be in a calm and matter-of-fact style. It is important to use at least correction and punishment. Reinforcing honesty about stealing is recommended but reinforcing non-stealing is not (Reid, 1975). Parents should also be alert to the possibility that stealing may be a symptom of some underlying problem (Comer, 1980; Dreikurs, 1964; Renshaw, 1977; Salk, 1972) and be open to discussing the case with a trained helping professional. They should be aware of the importance of induction (Hoffman, 1977) and the acceptability of shame and punishment (Renshaw, 1977). Shame fosters guilt and both are powerful inhibitors of unacceptable behaviors. Parents, should not hesitate to respond in such a way as to cause guilt in the offender. Public shame, however, is not recommended as the hurt and resentment overcomes any possible positive results of guilt feelings.

More specifically, Reid (1975) offers an appealing program for parents to follow. The reader must, at this point, be aware of the practical definition of stealing described earlier; it is the cornerstone of this program. Before instituting this program the parents need to be aware of Time Out procedures, be ready to record and consequent each theft without hesitation and be able to deal with this problem in a calm and unemotional fashion. Reid does not feel shame is productive and urges matter-of-fact and informational interchanges versus guilt inducing admonitions. This is probably the best approach if a structured behavioral treatment is instituted as it keeps things on a less emotional/personal level but lets the facts take care of themselves.

As before, stealing is defined by the child's possession of anything which they do not clearly own. The clinician must be careful here as different homes have different rules about in-house possessions. After evaluating this the definition of in-home stealing must be consistent but different from out-of-home stealing. Out-of-home stealing is not negotiable. Anything not clearly belonging to the child is considered stolen. The parents alone decide what is stolen on the basis of direct observation or a report from a reliable informant. When a stealing event is discovered the parents simply state that "according to our rules you have stolen _____" and apply the consequence as follows. Any arguing or denial gets one warning and then time out or a point loss if a token system is in effect. The interaction is calm, matter-of-fact and does not involve lectures or shame. Talking with the child about the theft is encouraged but not in the context of labeling or consequating an event. Every event is consequated and there are to be no excessive detective tactics such as searching pockets or rooms. Parents should simply be aware and investigate where new possessions came from. Two levels of punishment are advised: one hour of useful work or one day of grounding for stolen articles worth less than a dollar; two hours of work or two days grounding for articles costing more than a dollar. No other consequences are advised. Positive reinforcement of non-stealing is not recommended as some stealing will likely go undetected and thus covert stealing may be reinforced.

Reid (1975) recommended a program duration of at least six months after the last stealing event whereupon some negotiated "loosening" of structure may occur. During treatment, they recommend at least twice a week monitoring by the therapist. If supervision is reduced because of work/school schedules a phone check-in system will facilitate monitoring. The child calls in once every hour (later every two hours) and reports his whereabouts if there is any question about it at all. Including a phone number with this report allows parents to check the validity of the report if necessary and to contact adults who may report a stealing event out-of-home.

Conclusions and Considerations

Although, as school psychologists we are unaware of much of it, stealing appears to be rather wide spread behavior. Granted, many who steal "just a few times" will grow up to be responsible citizens. However, many will follow a social and legalagency path of chronic maladjustment. Many stealers are at serious risk. Though there are no typical stealers or typical (average) backgrounds, there is considerable data to support intelligent evaluation and effective treatment.

In view of this target behaviors relative rarity as a reason for referral it is unlikely that many school psychologists have become prevention oriented. Once it has occurred it is obviously in need of treatment. However, stealing is a vast social concern, highly predictive of later maladjustment and costly to both victim and society. Quality of parenting does relate to delinquency in general and stealing more specifically. Albeit indirectly, prevention is therefore feasible through parenting groups, classes, workshops, etc. In view of the predictive validity of parent reported stealing for a child's later legal involvement, school psychologists might routinely investigate this, offering full disclosure regarding the motivation of the question. This alone may be educational and perhaps motivational for some parents. Such parenting groups could cover a variety of issues that relate to later adjustment difficulties. However, if they made an impact only in terms of reduced delinquency proneness their time would be well spent.

Once the problem exists, the school psychologist should be well equipped to engineer an effective treatment approach. School psychologists have the necessary skills plus access to the people that provide the most supervision for all children; parents and teachers. In view of stealings covert nature, structure and supervision, and/or an extremely motivated (to change) thief will be necessary before this multiply reinforced behavior can be controlled.

Footnotes

1. All information regarding the Iowa Criminal Code and the Scott County Juvenile Diversion Program was obtained from Kathy Biscontine, Diversion Coordinator and Deputy Probation Officer via personal communication on 6/24/84.

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Child Sexual Abuse

Abstract: This chapter helps the reader understand the nature of child sexual abuse from a review of its incidence rate, the myths relating to sexual abuse of children and the family dynamics that tend to be prevalent in sexually abusive home situations. In this chapter the problem is considered primarily from an educational and psychological perspective, although the legal definitions and difficulty with definitions will also be discussed.. Useful symptomologies are discussed for determining whether or not a child has been a victim of sexual abuse and consider treatment programs and school-based curriculums which can be useful in helping children become aware of sexual abuse, how to protect themselves from sexual abuse, and where to get help if sexual abuse has occurred.

Chapter Outline

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Definition, Background and History

According to the National Center on Child Abuse and Neglect (1981), the sexual abuse of children is the "last remaining component of the maltreatment syndrome in children yet to be faced head on" (page 1). It encompasses a wide range of behavior including activities of using the child for pornographic purposes, the fondling of the child, the forceable penetration of the child, and the use of the child for masturbatory purposes. Child sexual abuse takes many forms and may involve varying degrees of emotional traumatization for the child. Sexual abuse is defined in a variety of ways due to the difficulty in determining such issues as the age of consent and the ambiguities in laws from state to state.

For the purposes of this paper, the National Center on Child Abuse and Neglect's definition will be used. Sexual abuse is defined as, "Contacts or interactions between a child and adult, when the child is being used for the sexual stimulation of that adult or another person." Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim, or when the abuser is in a position of power or control over another child.

The critical issue in this definition is responsibility. In other words, in order for a child to be a victim of sexual abuse, the person abusing the child must be in a position of responsibility or authority over that child. To further add to the confusion, legal definitions of child sexual abuse vary; for example, the victim's age and relationship to the perpetrator are taken into account in many states. Furthermore, because most child abuse reporting laws address themselves to maltreatment by parents or persons legally responsible for a child's welfare, an act of sexual abuse committed by a person outside the family is defined and handled quite differently from the same act committed by someone legally responsible for the child (MacFarlane, 1978).

The Federal Child Abuse Prevention and Treatment Act of 1974, subsection 5, paragraph 3, also includes the obscene or pornographic photographing, filming, or depiction of children for commercial purposes, or the rape, molestation, incest, prostitution, or other such forms of sexual exploration of children under circumstances which indicate that the child's health or welfare is harmed or threatened thereby. (U.S. Department of Health and Human Services, 1981).

As previously stated, each state deals differently with the issue of sexual abuse and clearly the age of the child in question is a major issue. In Iowa the age of consent is significantly taken into account when decisions are made whether to prosecute or not to prosecute on a case of sexual abuse.

The Iowa Code, Chapter 709, deals exclusively with the issue of sexual abuse. It also deals with the issue of sexual abuse when the person abusing the child is not in a position of authority or responsibility over the child. This part of the law is referred to in sections 709.8 entitled, "Lascivious Acts With a Child." It is defined as any person 18 years or older who performs any of the following acts with a child with or without his or her consent unless they are married to each other for the purpose of arousing or satisfying the sexual desires of either of them:

1. fondle or touch the pubic area or genitals of a child.
2. permit a child to fondle or touch his or her genitals or pubic area.
3. solicit a child to engage in a sex act.
4. inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort on him or her.

Any person who violates a provision of this section shall, upon conviction, be guilty of a Class D felony. In the Iowa Code the definition of a child is any person under the age of 14 years. The interested reader may wish to look at the varying degrees of sexual abuse as defined by the Iowa Code and are included as Appendix A to this chapter.

It is difficult to get a true estimate of how many children are involved in sexual abuse in this country: variations in reporting statutes among the states, reluctance of individuals who are familiar with or aware of sexual abuse to report it due to the perceived and misguided notions of causing damage to the family or putting the child through the rigors of the criminal or Department of Social Service reporting systems. There is also some confusion with regards to separating normal childhood sexuality and curiosity from sexual abuse. For example, if a 6 year old girl is involved in sexual exploration with her 7 or 8 year old brother, this may well be viewed by many as inappropriate behavior, but legally would not be defined as sexual abuse because the ages and responsibilities of the children would be seen as fairly equal. This would also apply to perhaps a 14 year old girl and her 16 year old brother. Under these conditions, the parents may well be guilty of some neglect in not educating children in terms of appropriate and inappropriate behavior, but it would still not be defined as sexual abuse under the law. Depending upon which studies are read, the incidence of sexual abuse in this country varies greatly. Fontana (1982) reports that in nearly every United States city as many as 4,000 cases of sexual abuse may occur each year. He also reports studies that indicate by the age of 18 as many as 1/3 of all children may experience some form of childhood sexual abuse. He also clearly points out that the actual incidence is not available, again because of the "taboo" aspect which often causes a family to keep the incident a secret because of their guilt, shame, or simply general ignorance. The statistical problem as he points out, is further compounded by physicians who not only resist recognizing sexual abuse when it confronts them, but also refuse to report it (page 1). There is a great fear that the family may dissolve if the abuse is revealed and further the court system in many states is so rigid in insisting upon such demanding rules of evidence that there is an extremely low conviction and "proval" rate. Russell (1983), in a study of 930 women in San Francisco, found that 16% reported at least one experience of intrafamilial sexual abuse before the age of 18, 12% reported at least one experience before the age of 14, and 31% reported at least one experience of extrafamilial sexual abuse before the age of 18. When the results are fully examined, 38% of these 930 women reported at least one experience before the age of 18, and 28% at least one experience before the age of 14. Russell further states that of these individuals, only 2% of the cases of intrafamilial and 6% of the cases of extrafamilial sexual abuse were ever reported to the police. Sanford (1980), in her widely acclaimed book The Silent Children, indicates that there is a 1 in 4 chance that a girl will be the victim of incest, child molestation, or rape by the time she reaches 18 years of age (pg. 3). With regards to male victims, the data is far less revealing, but Ms. Sanford says that approximately one male child is victimized for every 10 females (pg. 123). DeFrancis (1969), of the American Humane Society studied 263 child victims of sexual abuse and indicates that probably 50% to 80% of all incidents go unreported (pg. VII). Finkelhor (1979) studied 796 college students and found that 19.2% females had been victimized in childhood and 8.6% of the males had been victimized (pg. 53). Rush (1980) indicated if we look at the Finkelhor study as well as the Kinsey Report (1953), it appears that approximately 28 million of the combined male and female population will experience a sexual encounter with an adult while still in childhood. Rush, in The Best Kept Secret, reports that of 5,058 reported sex crimes in New York City in 1975, 27.2% of the victims were under the age of 14 and that 25% of all victims of reported rape were under the age of 12 (pg. 12). Rush points out that 70% of all young prostitutes and 80% of all female drug users were found to have been sexually assaulted in childhood by a family member. Rush found upwards of 80% of children at the Juvenile Hall in southern California had been sexually molested regardless of the reasons that placed them there. The study goes on to indicate that in Washington, D.C. it was found that sexually abused children were more common among the children's hospital patients than broken bones and tonsillectomies. Most authors in this field now consider child sexual abuse a hidden and national epidemic which is far more common than most Americans are willing to acknowledge or recognize. It is difficult to pick up any newspaper in this country on any given day without seeing at least one discovery of far reaching sexual abuse. There is no question than that sexual abuse of children is at a national epidemic level. Most experts seem to believe that one way to prevent sexual abuse is to teach children how to protect themselves (Stark, 1984).

While the issue of sexual abuse of children has been presented to children from time to time, in most cases the information that is given to them deals with the stereotype of the child molester being the "dirty old man." Children have been told, and properly so, about not getting into a stranger's car and avoiding the people that they do not know who offer them candy, or are standing on the school ground in a raincoat. In fact, as most studies point out (Finkelhor, 1979) that most abusers are not dirty old men, that in fact many appear to be quite respectful and most are relatively young. He goes on to say that most child molesters are well known to their victims, with three-quarters or more being friends, neighbors or relatives. In fact, more than 50% of children that are sexually abused are done so by relatives or direct family members. As we look at the stereotypes of child molesters, we are quickly shocked into realizing that sexual abuse of children is an extremely democratic process; it involves families from all social, cultural, religious and ethnic groups. Newsweek, in May of 1984, presented an article in which it cited a physician who was arrested on charges of sodomy and indecent liberties with a 14 year old, an artistic director for children's theatre who was charged with sexually abusing three male students, and several cases are known to this author whereby the perpetrators were a minister and a superintendent of schools. This simply serves to point out that there is no group, no matter how high in the social ladder, that is necessarily immune from this problem.

While the numbers presented may appear alarming, what may be equally alarming is the age at which sexual abuse generally begins. Stark, reporting in Psychology Today, indicated that incestuous relationships usually begin when a daughter is between six and 11 years of age, and last anywhere from two to seven years. This author has been involved in cases where children as young as six months of age have been sexually abused, and children as young as two years of age have been treated for gonorrhea of the vaginal area and mouth.

When we deal with the issue of incest, which can be defined as sexual intercourse between persons too closely related to marry legally (Jones, 1982) we run into the problem that state laws vary in their legal definitions. Some states recognize only sexual intercourse among blood relatives, whereas other states define incest as any sexual relationship between various combinations of legal relatives, such as adoptive or step-parents and their children. Jones indicates, and it is widely accepted by other sources (Rush, 1980; Sanford, 1980; Adams and Fay, 1981), that brother-sister incest is the most common type; however, father-daughter incest accounts for about 75% of reported cases. Jones indicates that mother-son incest is considered one of the most pathologic types with psychosis often present in one or both of the pair. Brother-sister incest probably has the least behavioral consequences since the ages of the brother and sister are fairly close, with equal power distribution and consent existing between the two parties. This type of incest is least likely to be reported, since in most cases, it is not done under duress.

CHARACTERISTICS OF OFFENDERS

DeFrancis (1969) dispelled many of the myths about sexual offenders. In his study published by the American Humane Association, he found the following:

1. the median age of the offenders was 31.32 years.
2. 21% were under 20 years of age.
3. only 10% of the offenders were over the age of 50.
4. the racial distribution was almost identical to that of the victim.
5. only 15% of the offenders had a prior record of criminal conviction, with only 7% having had convictions for sex crimes.
6. 90% to 97% of the perpetrators were male.

HISTORICAL ANTECEDENTS

Sexual abuse of children is certainly not something new. In fact, the history of sexual abuse of children dates back almost as long as recorded history. Florence Rush, in The Best Kept Secret, provides a comprehensive history of sexual abuse suggesting that both the Bible and the Talmud encouraged sex between men and very little girls in marriage, concubinage and slavery. The Talmud, the ancient Jewish writing, held that a female child of three years and one day could be betrothed by sexual intercourse with her father's permission. Intercourse with one younger was not a crime, but invalid. If a prospective groom would penetrate the child just once more after her third birthday, he could legitimately claim his promised bride. Rush further goes on to say that in early Christianity, in the 6th century, Pope Gregory decreed that any female taken by a man in copulation belonged to him and his kindred. Gratian, a 12th century ecclesiastic and founder of canon law, set forth that while consent was desirable, conjugal union by coitus was rendered indissoluble, regardless of age or mutual consent. Pope Alexander the III said if sexual intercourse had taken place with a child or a barren woman, the marriage could not be dissolved. The early church fathers apparently had in mind that penetration qualified a child as ripe for marriage, regardless of age. Rush says that where in the Hebrew tradition sex with a child under three was considered invalid, so under Christianity was sex with a child under seven considered invalid; and in fact, sex with a child under seven was considered inconsequential.

Under 16th century English law the rape of a nonresisting child was considered a misdemeanor and therefore an individual who had raped a child who did not put up a struggle would not be convicted of the charge of rape. By 1576 however, this had changed, and English jurists ruled age 10 to be the legal age where a female child could consent to sex, and 12 remained the legal age at which she could consent to marriage.

In the Greek culture, according to Rush, Greek poetry abounds with men swooning for the "tender flower of youth and thighs and delicious mouth of pubescent boys" (pg. 52). The Greek rules did not esteem homosexuality per se, but rather sex between men and boys was deemed desirable. Once a boy matured, custom demanded that the lovers part, and the boy, now entering manhood was expected to, in turn, pursue women and other young boys. In ancient Greece, according to Rush, there is as many boys as females in brothels with free boys as well as slaves available for hire.

The United States' story was much the same. During the colonial period young indentured servants were often used for sexual gratification and in particular southern slave owners exploited 11, 12 and 13 year old girls for breeding, for sale or hire out to brothels. West coast traders did lucrative business in purchasing Chinese girls and selling them at a profit.

As late as 1955 child marriage was still legal in the country of India and as late as 1928 one Indian leader claimed that if a girl was not married before puberty there was a danger of her becoming a bad character. It is easily seen that most societies in their developmental periods not only condoned sexual use of children but actively supported and encouraged it. It was not until the latter part of the 19th or 20th centuries in some countries where this practice began to be viewed as distasteful and illegal.

EMERGENCE OF THE FREUDIAN THEORY

One might wonder with our current state of concern about child sexual abuse, why it is so difficult for people to believe that children are victims. One of the best reasons for these confusions and questions deals with the emergence of the Freudian theory of sexuality (Rush, 1980). In 1905, Sigmund Freud presented his theory on infant sexuality and stated that very small children had strong, erotic drives. The basic premises of the Oedipus and Electra complex, which essentially state that boys really want to sleep with their mothers and girls with their fathers. Freud claimed that children who reported sexual abuse by adults had imagined or fantasized the experience that they had had. Today authors highly question that interpretation and recognize that children are very much aware of when they have been exploited by adults. Rush shares her childhood experience of being molested by her dentist. She was told that getting her teeth worked on was not that bad, and when the dentist's hands were between her legs, that this was a fantasy and was not founded in fact. Rush says that as children become more and more ignored and disbelieved they begin to lose their sense of their bearings, and begin to question whether or not they even know what reality was. Freud found that in his hysteria patients their neurosis was caused by sexual assault. The exposure of repeated incrimination of fathers by his patients seemed to make him very uneasy, and in his writings in 1933 he reassigned the abuse to a female fantasy and disavowed it as erroneous. "Almost all of my women patients told me that they have been seduced by their fathers. I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from fantasies and not from real occurrences" (Rush, 1980, pg. 83). Freud was more at ease with the fantasy rather than the reality of sexual abuse and was more comfortable yet when he could name the mother, rather than the father as the seducer. When he implicated the mother, he assured the reader that maternal seduction was based on reality. Rush quotes Freud in saying that the female, having no penis, is biologically inferior and could only achieve an approximation of human completion by "acquisition of the penis through sexual intercourse and eventually by bearing a child." This biologic "deficiency" represented itself in a fantasy of an everlasting desire for the coveted penis and was implicit in her biology. Therefore, Freud found that the incestuous wish of girls for their fathers was a predisposition into traumas giving rise to excitation and fixation.

Rush suggests that the early disciples of Freud who accepted this "penis envy" as axiomatic soon surpassed Freud in establishing female "organ inferiority" as the crucial problem of molested children. Freud's followers say that little girls who were molested were preinclined towards their own violation (pg. 96). Rush asserts that even today some doctors, nurses, educators and social workers who have never heard of infant sexuality or penis envy readily accept Freud's theorizing that children are sexy, and that they participate in, and even instigate, their own molestation. They may say in the in famous words of every child molester, "The kid really asked for it." Rush notes books as late as 1970, such as John James, Facts of Life, "that there is incontrovertible fact, very hard for some of us to accept, that in certain cases it is not the man who inaugurates the trouble." The novel, Lolita, describes what may well happen. Perhaps, in all innocence, she is the temptress and not the man. In the 1968 book, Vulnerable Children by Lindy Burton, Rush contends that the molester was the real victim, while the young girls were juvenile delinquents acting out their pathology. Rush states that during her years as a social worker, if the child showed no visible scars, it was assumed that the experience of being sexually abused had been harmless; if she had problems, was difficult, angry, failed in school, attracted boys or became pregnant, she was diagnosed as acting out her incestuous wish for her father or other sexual fantasies. In many cases, because she was abused, she was presumed to be sexually promiscuous and finally, through absolutely no fault of her own, was often sent to a reformatory.

FAMILY PATTERNS OF INCEST

Jones (1982) identifies three basic types of families involved in father-daughter incest: the intrafamilial, the multiproblem, and the accidental. In the intrafamilial type, the family is seldom known to courts or public agencies. This is the type of family that seems to be leading a quiet, normal life in the community but, as Jones points out, family members tend to have very limited contact with the outside world. The incestuous relationships are not single acts of activity, but last for several years. The dynamics within the family usually involve the triad of the father, the mother and the child who is the victim. The husband, according to Jones, usually has a passive, introverted type of personality and usually a weak sexual relationship with the wife. He generally turns to the relationship with his daughter during a period of stress, out of loneliness and dependency. Generally, the sexual activity is of an affectionate nature. It may not be primarily sexually motivated; instead, it may represent a need for affection. The mother in this relationship generally is tangential to the family and may be unavailable sexually because of illness or because she works evenings. She may be aware of the incestuous relationship, but ignore it or actually encourage it because the daughter is fulfilling a role that she does not wish to fill. Jones maintains that in this type of familial situation parents may agree consciously or unconsciously that the incestuous relationship is more acceptable than an extramarital one which could cause the breakup of the marriage and the family. Jones reports, and is confirmed by other sources (Adams and Fay, 1981), that the girls in this family may become the "little mothers" around the house and assume household duties that a mother would usually fulfill. This author has interviewed children who seem to have a abundance of responsibilities around the home and are often responsible for taking care of smaller brothers and sisters, and occasionally cooking and cleaning duties around the home. Perhaps it's not a very large step from being a "little mother" to being a "little wife."

In the multiproblem type of incestuous family, incest may be only one small part of the total family disorganization. In this family situation alcoholism, violence, delinquency, school problems, physical abuse, mental illness and drug abuse are frequently involved. These families, according to Jones, tend not to form any close interpersonal relationships and females are frequently treated as sex objects. Children may be abused physically as well as sexually and the fathers may seduce other children as well as their own. In this situation, mothers may not encourage the father-daughter relationship but often feel powerless to prevent it. They may ignore the incest in an attempt to prevent the father's violent behavior.

In both of these kinds of families as children grow older and become aware of the fact that they have been sexually used, they may develop guilt feelings as they reach adolescence. However, as Jones points out, they may well be afraid to withdraw from the relationship out of fear that to do so would destroy the family and whatever security it may provide. Both types of incestuous incestuous relationships often initially involve the older daughter and later younger female siblings when the older girl either leave home or is able to terminate the relationship.

The third type of incestuous father-daughter relationship is the accidental one where the father, perhaps under the influence of alcohol, may commit a sexual act that generally does not involve intercourse. This activity is likely to be a single event with the father typically feeling very guilty and remorseful.

The impact of incest is questioned in terms of the psychological damage that may be created. Jones found less than 10% of children were normal psychologically at the time of initial evaluation. Follow-up studies by Jones reported that less than 25% of children were making a reasonable adjustment although he does not define what reasonable adjustment is.

Mrazek (1981) indicates that the father in an incestuous relationship has a background of emotional deprivation, experiencing rejection by his mother and abandonment by his father. If the father had not left the home, he was often harsh and authoritarian. Psychological disturbances range from minimal abnormality to psychotic disorder. Common diagnoses include sociopathological behavior, pedophilia, dependent personality, and paranoid personality disorder. MMPI studies done by Panton (1979) indicate high elevation on the social introversion scale and found that males who sexually molest children have profile configurations indicative of self-alienation, despondency, rigidity, inhibition, feelings of insecurity, and fear of not being able to function adequately in heterosexual relationships. The incestuous sample appeared to be more socially introverted, whereas the child molester in general is more immature in psychosexual functioning. Panton found that child molestors in general were not predisposed towards the use of violence in seeking to satisfy their sexual needs. Panton also found that nonviolent molesters had feelings of affection towards and usually felt comfortable and functionally secure in the presence of their female child victims. The choice of victims for both the incestuous father and the nonviolent molester appeared to be motivated in large part by fears of heterosexual rejection or failure on the part of an emotionally weak, ineffectual male having feelings of inadequacy and psychosexual insecurity.

Mrazek (1979, p. 100) found that male molestors frequently have sex with their wives and several of their own children, but are unwilling to seek sexual partners outside of the nuclear family, because of a need to maintain the public facade of a stable and competent father figure. Mrazek says that for some fathers the incest only occurs during high stress periods and may be triggered by excessive drinking or when the marital tension is so high that there is sexual estrangement and minimal communication between husband and wife. Mrazek suggests that while domination and brutal violence against children and wife characterize a subgroup of these fathers, others are best described as ineffectual, gentle men who are seeking nurturance and approval from their daughters. In the father-daughter relationship, the daughter probably has a role reversal with the mother and is likely to be passive and dependent. Younger daughters are more at risk if the mother has allowed the sexual relationship between the father and the older daughter to continue. Frightened and lonely, the girl may accept the sexual advances from the father figure as signs of "affection and specialness." Mrazek goes on to say that some daughters may play an active initiating role in the sexual relationship, and in general, the girl is of average intelligence, but may be doing poorly in school. Mothers in this relationship are unable to show much affection and love to the husband and children. They may have also been sexually abused as children but are reluctant to discuss it. The mother's absence from the home due to death, divorce, separation, illness, or long work hours may increase the chance for a sexual relationship between the father and the daughter. Even if the mother has not colluded in the onset of the incest, she is usually seen as partially responsible for its continuation through her failure to take any action that would terminate it. Mrazek (p. 101) states that in the much rarer mother-son incest, the mother may be alcoholic or have other severe character problems. Typically, she vacillates between being very rejecting of the son during the formative years with gross over protection of him. She is likely to have been overly promiscuous or have had multiple lovers and husbands. Usually, she will deny any harmful influence that she has had on the child. The son in this type of relationship may have nightmares of a persecuting nature, poor school performance and other behavior problems, including delinquency. He often has had a variety of sexual experiences, including ones with other members of his family that may have served to weaken his taboo against having sex with his mother. The father figure in this type of relationship has often been absent from the home, or if he is at home, is probably very passive in the face of a very domineering wife.

Assessment and Diagnosis

Sexual abuse is not an easy one to evaluate. There are few overt signs that can be seen, and no tests that will clearly point out the child who is being sexually abused. For that reason, the psychologist has to pay acute attention to behaviors that the child is manifesting which suggest sexual abuse. Brassard, Tyler, and Kehle (1983) indicated that the behavioral and physical signs that school psychologists should be alert for include:

1. difficulty in walking or sitting.
2. torn, stained, or bloody underclothing.
3. complaints of pain or itching in the genital area.
4. bruises or bleeding in the external genitalia, vaginal or anal areas.
5. venereal disease, particularly in a child under 13.
6. poor peer relationships.
7. behavior typical of a younger child such as bedwetting or infan-tile, withdrawn or even retarded behavior.
8. a change in appetite or sleeping patterns.

9. a need for unusual degree of reassurance from parent and excessive clinging, particularly when the offender is around.
10. unwillingness to change for gym or participate in physical activities.
11. fear and anxiety regarding the opposite sex.
12. bizarre, sophisticated, or unusual sexual knowledge or behavior for the child's age.
13. indiscriminate hugging, kissing, or seductive behavior with children or adults.

For example, a youngster referred because it was observed by the playground supervisor at the child's school that the youngster was getting on top of other children and imitating copulation. The child was referred because of behavior problems. In an interview, the child advised this examiner that he had learned to do this from his 14 year old brother while at home. In another illustration, a young girl in second grade was referred because she was regularly masturbating in the classroom. While it is recognized that children do masturbate, excessive masturbation should be looked upon with concern. In talking with the girl, she revealed that her 14 year old brother was having intercourse with her when she was left in his care and she was bribed with money not to tell. In another situation, a five year old girl in kindergarten was presenting a doll that she had received at show and tell. When the teacher asked her why she got the doll, whether it was her birthday or something special, she began to fidget and indicated that her older brother had given it to her. The teacher indicated that the brother seems like he was very nice and indicated that he must love the little girl quite a bit. The girl shook her head yes, and when the teacher pursued with what nice things he had done the little girl said that he told her not to tell. At this point the teacher became suspicious and requested the authors advice. Upon review with the parents it came out that the girl was masturbating the brother and he, in turn, was fondling her genitals. Another case deals with a little girl drawing sexually explicit pictures in school. While a draw-a-person is not necessarily indicative of anything, the explicitness of her drawings led school personnel to refer her for possible emotional problems. Again, the interview revealed that she had been sexually molested.

Riggs (1982) adds to the list of behavioral indicators of incest or sexual abuse the following behaviors:

1. excessive withdrawal or child engaging in fantasies.
2. overly sophisticated knowledge and interest in sexual acts and vocabulary.
3. and extremely critical is the expression by the child that he/ she has been sexually involved with an adult.
4. expressions by other children that the child told them of the sexual experience.
5. manifestations of the child's schoolwork, art, poems and stories of usual sexual behaviors or themes.
6. repeated attempts of the child to run away from home.
7. the child turns to the use of drugs or alcohol.
8. poor peer relationships.

In evaluation, Riggs goes on to say that evidence to consider in the evaluation of the family are:

1. jealousy or severe overprotectiveness of the child by the parent.
2. isolation or alienation of the child and family members within the community.
3. frequent absences from home by one of the caretakers or parents of the child.
4. a pattern of rigid, restrictive control by the father of one or more of the female children.
5. a father whose behavior is characterized by frequent drinking or by alcoholism and a history of abusive, unfeeling treatment of other family members.
6. an inordinate participation by the father in the dynamics of the family life and a concomitant overdependency on him by the mother.

Wishon (1979), at the Conference of the National Association for the Education of Young Children, indicated that other behaviors to be suspicious of are:

1. aggressive, disruptive or destructive acting out behavior.
2. shy, withdrawn, passive or overly compliant behavior.
3. habitual truancy or chronic tardiness without adequate excuse.
4. sexual precociousness.
5. coming to school much too early or hanging around school after dismissal.
6. appearing to be in need of frequent medical attention.
7. the child complains of maltreatment.
8. the behavior of the child's parents appears bizarre. They may appear aggressive, abusive or apathetic when approached about problems and they express very little concern for the child.
9. unexplainable, noticeably subnormal schoolwork.

Psychologists need to keep in mind that children, particularly young children, may lack vocabulary to talk about abuse and simply do not know how to explain it. tell. Listening for vague terms or innuendos may create an opportunity for psychologists to explore in more detail what the child means. Statements like, "I don't like Mr. Smith anymore," or "My uncle does weird things," may sound innocuous and vague, and perhaps they are, but occasionally it may be of value to ask for further examples or clarification of what the child means. Watching the child's body language, particularly when they say, "Well,I can't tell," or they have given their promise not to tell, may alert the psychologist that there is something suspicious going on.

The psychologist needs to remember, particularly with the younger child, that there is often a very close relationship between the child and the abuser. The child will be very reluctant to say anything which they might perceive as getting that person in trouble. If the psychologist reacts with shock or dismay, or becomes too insistent when probing into this area, the child may become silent or deny anything has gone on. The psychologist will have to present a nonjudgmental and accepting attitude to the child, letting the child know that they are there to help them with whatever problems that they are having, and then allow the child their own time in which to talk about their difficulty. During the evaluation, it is critical to reassure the child, and go slowly. Indicate that you are glad that they have told you. Under no conditions pressure the child to talk. Remember that the child may feel guilty for saying something to you, or may feel guilty for not saying something to you. Make sure the child realizes whatever they do is okay and that you will believe what they have told you. Adams and Fay (1981, p. 63) point out, children do not make up stories about sexual assault. They may have difficulty describing the incidenct, but this should not be a cause for disbelief. Make sure that you let them know that it was not their fault, and that you're sorry about what happened, and that you will do your best to protect and support them. Assure the child that you are not trying to punish anyone or blame anyone, simply trying to find out what happened, so that the child and the family can get the help they need to correct the problem.

Summit (1982) lists six rules for evaluating and managing incestuous child abuse.

1. Do not relate to only one person. Evaluations should be coordinated so that each family member has a sense of responsibility and involvement in the evaluation and management. All viewpoints from all family members will give more clues to the relationships so that a course of action can be better planned.

2. Don't rush into family therapy. It should not be assumed that the family is capable of living together before the basic assurances of protection, respect and autonomy are established. In this area perhaps the school psychologist can be of some assistance in coordinating the work of the protective agencies so that the child is represented and has someone that they can see as a supporter.

3. Don't try to manage the situation alone. Keep in mind that families with sexual abuse are complex and extremely dysfunctional with many needs and that perhaps several individuals or agencies working together may be more productive in getting the family to be functional.

4. Do not hide the problem from society. School psychologists must recognize they are mandatory reporters. When it is determined that there is a possible sexual abuse case, the psychologist is bound, not only by common sense ethics, but by law to seek the participation and the involvement of protective agencies. As Summit (1982) points out, a school psychologist can be a participating member in the team of professionals that can draw upon each other for guidance and support in helping the youngster.

5. Don't keep secrets. Children need to know in the evaluation that you are there to help them, but that you have a legal obli-

gation to share this information with those protective agencies already mentioned. Remember that these children have difficulty trusting other people, since their trust has been betrayed and they need to know that you're going to be honest and forthright with them. They should be informed as to what you're going to do so that there are no surprises for them.

6. Do not jump to any psychodynamic conclusions. Keep in mind that while these children may present themselves as very seductive and sexually sophisticated youngsters, they have been abused and are simply acting out the impact of that abuse.

Brassard (1983) states, whenever possible, school psychologists should allow trained personnel from a child abuse agency to handle interviews, or to manage them jointly with the child abuse agencies. While children of sexual abuse may well demonstrate school related behavioral problems, sexual abuse is not largely a school problem and would probably be more appropriately handled through an outside agency such as a child abuse team from the Department of Human Services or through a mental health clinic. When the school psychologist feels comfortable with this subject and has knowledge of the youngster, when ("working in conjunction with the child abuse agency.") s/he can be extremely helpful. Brassard goes on to suggest that when interviewing the child it would be a good idea to record the interview on tape and inform the child of such. She also suggests the following as being helpful:

1. Maintain an atmosphere of trust with the child.
2. Be sensitive to the child's nonverbal clues such as body language in addition to using language that the child clearly understands. If the child uses terms that may be ambiguous ask for clarification.
3. Keep in mind that the children, particularly young children, rarely lie about sexual abuse.
4. Assure the child that they have done nothing wrong and that they will have your continued support.
5. Do not suggest, under any circumstances, answers to the child And avoid probing or pressing for answers if the child is reluctant to give them.
6. Do not display any horror, shock or disapproval of parents, child or situation. Keep in mind that, particularly in cases of intrafamilial sexual abuse, that the child likely has a very close bond with the prepetrator, and they are already feeling extremely uncomfortable and guilty about disclosing this information. By displaying your own value system to the child, you stand the likelihood of further making the child feel guilty or bad about disclosing.
7. Do not ask or suggest to the child that the interview should be concealed from the parents. Again, keep in mind that these children have often been told that this is a secret that should not be shared. By telling the child to continue keeping secrets further reinforces the fact that this is appropriate behavior.

Broadhurst (1979) also clearly points out that it is not the job of the school psychologist to "prove" abuse. School psychologists need to be familiar with the laws regarding reporting child abuse and keep in mind that they are mandatory reporters of "suspected abuse." Only statements regarding their suspicions are required; not proof of abuse. States differ in their procedures as to how this is done, but in general, if a school psychologist suspects the child is being abused, an oral report should go to the Department of Human Services' Child Abuse Department followed, usually within one or two days, by a written report. Psychologists should keep in mind that every state provides immunity from civil liability and/or criminal penalty for those who report, providing the report is made in good faith.

Mrazek (1981) offers some cautions to the individuals doing the evaluation. Mrazek, in his psychiatric examination of the sexually abused child, indicates that it is wise to keep in mind that the role of the evaluator is not to play interrogator, but should allow the child to raise the topic of sexual abuse themselves. By listening to the child relate events, you may be able to assess the child's capacity to cope with the situation, and have some indications of their levels of anxiety, depression, and/or anger. Again, if the child is reluctant to discuss the events or denies that they ever occurred, do not attempt to coerce the information out of them. Under certain circumstances, and with the competence and skill of the school psychologist, the use of anatomically correct dolls may be helpful in giving clues to the nature and extent of the sexual abuse. The use of drawings of families and self may also give these clues but the psychologist must keep in mind that these are clues and not etched-in-stone facts. Mrazek also suggests that assessment of the child's intelligence is important so that disposition and treatment can take into account on the child's ability to handle different kinds of treatment. Projective tests can be useful particularly for inhibited children and again may give further clues into the child's level of perceptual disorganization and confusion. Mrazek does not feel that the sex of the evaluator is the most essential issue, rather that the diagnostician be a patient, gentle and noncritical person. However, he does point out that if the child has been physically traumatized, then perhaps the sex of the psychologist or evaluator may be an important factor to consider in determining who would be most effective in working with the child.

Intervention

This section will give information regarding the short and long term affects of sexual abuse and to provide some insight into various treatment methods and problems which the psychologists may be confronted with if they attempt to work with children who are victims of sexual abuse. Again, treatment should only be undertaken by individuals who are comfortable and familiar with this problem. In general, the treatment of child sexual abuse is not a school problem, rather is viewed as a family systems problem in which treatment should be undertaken by agencies that are located within the community. In the author's opinion, school psychologists may be involved with children who have been victims of sexual abuse but would be treating this problem only as it relates to difficulties that they are having in school.

It is appropriate for psychologists to become involved in treatment at the prevention level. School psychologists can play a critical role in helping prevent sexual abuse by presenting programs to children, parents, teachers, and community leaders so that prevention and treatment programs can be developed which will have the affect of reducing the number of children who may be victimized. A review of several of these programs will be presented at the conclusion of this section.

Meiselman (1981), indicates there has been considerable change in the way we treat victims of sexual abuse and incest since the 1970's. Initially, when incest or sexual abuse was detected, there was little doubt that the social response was in many cases more harmful to the child than the actual abuse itself. She states that children who reported incest could very reasonably expect the splitting up of the family with the father possibly in prison for long periods of time, the mother and children deprived of economic support, perhaps losing homes and automobiles, etc., and the child herself may well have been separated from the family, placed in a foster home or institution and blamed for all of the problems by the disclosure. This situation is in the process of changing and it is now the goal of treatment to maintain the intactness of the family wherever possible and as long as the child can be reasonably protected within that home. There is no question that by the family remaining intact as long as possible it will reduce the child's feelings of guilt that the family was "destroyed" and it was all their fault.

Porter, Blick and Sgroi (1982) indicate that the short and long term affects and the need for treatment often address the following issues:

1. the child's "damaged goods" syndrome.
2. guilt.
3. fear.
4. depression.
5. low self-esteem and poor social skills.
6. repressed anger and hostility.
7. impaired ability to trust.
8. blurred role boundaries and role confusion.
9. pseudomaturity coupled with failure to accomplish developmental tasks.
10. self-mastery and control.

Sgroi claims that the first five issues are likely to affect all children who have been sexually abused regardless of the identity of the abuser. The last five issues, numbers 6 through 10, are more likely to affect intrafamilial sexual abuse victims.

Slager-Jorne (1978) demonstrates some of the short term problems presented by victims of sexual abuse. She reports a 10 year old boy who had been sexually abused since age 4 who demonstrated aggressive behavior with young children at school. She further reports a 13 year old girl who was very seductive with any strange men that she saw. A third case, a 13 year old girl with preoccupation with sex at school, was raped at age 8. A fourth case presented was a 4 year old boy sexually molested who was exposing himself. While it is true that not all children will present these kinds of problems, these are examples of behavior problems seen by Slager-Jorne of children who have been sexually abused.

Silbert and Pines (1983) interviewed 200 female prostitutes in the San Francisco Bay area to determine what effect sexual exploitation during their childhood had on their becoming a prostitute. Seventy percent of the 200 individuals, ages 10 to 46, said that exploitation effected their decision. Seventy-eight percent of them said they became prostitutes as juveniles. It is also interesting to note that two-thirds of this sample came from families of middle or higher incomes. The subjects also indicated that in 63% of the cases they never told anyone about it because they either did not know what to do or who to tell, or they were too afraid of what repercussions might occur. It is also interesting to note that 98% of the subjects reported negative feelings about themselves, about men, about sex, and about their mothers.

Steele and Alexander (1981) indicate that the delayed effects of sexual abuse situations leaves victims with feelings of severe inferiority, poor basic trust, repressed anger, unresolved identifications and fixations, and profound difficulties in establishing and maintaining warm, successful human relationships. They also report in many clients sexual dysfunctions and aberrant sexual behaviors occurring later in life. Along with these feelings, clients report shame, guilt, and fear of social disapproval making it even more difficult for them to cope with the underlying feelings of helplessness and fear.

Mrazek and Mrazek (1981, p. 242-243), in reviewing studies of the short term and long term effects of sexual abuse, report problems in areas of sexual adjustment such as increased masturbatory activity, sudden rushes into hetero-sexual activities, acting out sexual delinquency, promiscuity, prostitution, as well as problems in interpersonal difficulties, such as being frightened by contacts with adults and difficulty in developing social relationships as well as running away from home. Educational problems noted include learning difficulties and mental retardation as well as other psychological problems that studies have noted guilt and shame, nailbiting, facades of maturity, impulsive self-damaging behavior, and general loss of self-esteem. Mrazek and Mrazek also point out that there are studies that found no ill effects, such as the widely publicized Burton (1968) study, where she concluded that sexual assault of children does not have any particular detrimental effects on their subsequent personality development except for the significant increase in their attention seeking behavior. This study has been widely criticized for its methodology. Mrazek and Mrazek (1981) concluded that the study may well have been biased by the researchers' conviction in the truth of the hypothesis.

There are groups of people who seriously question the impact of sexual abuse on children and say programs to educate children may breed a hysteria in which adults who show physical affection for children may be suspected as molesters (Katz, 1984). Summitt (1980) reports on the Rene Guyon Society who claims that children need sex with compassionate adults to reduce violent antagonisms suppossedly aroused by societies repression and guilt. They claim that sexual repression is the cause of depression, suicide, delinquency, gang warfare, assault, and a host of other social problems. They use the slogan "sex by year eight or else it's too late" and the group advocates for the sexual rights for children including abolition of laws restricting incest and sexual abuse. This groups claims a membership of 2,000 parents and psychiatrists and promotes their cause nationally. It is, however, a safe assumption to say that most researchers view the effects of sexual abuse on children as extremely damaging and requiring intervention. Elsworth (1981), found a significant drop in the verbal I.Q., and a significant lowering of the children's self-concepts. She added that the skills that they will have to develop are increased communication skills and insight into their lack of responsibility for the sexual abusing situation.

Spencer (1978), in reviewing the impact of sexual abuse on children, also points out that there is an extremely high correlation between early sexual trauma and later drug abuse. Spencer reports studies that indicate a high incidence of drug abuse and promiscuity in the younger female clients between the ages of 12 and 14 and also a high incidence of suicidal gestures among the female group. Spencer goes on to say that many girls who have experienced early sexual trauma may exhibit much self-destructive behavior by running away from home as well as turning to drugs, suicidal attempts or prostitution. The long term effect she sees is the girls' inability to form meaningful relationships, which causes progressive promiscuity.

Treatment Goals and Considerations

While the primary focus of this chapter has been on the serious and detrimental effects of sexual abuse on children, the reader should not take it for granted that all children are traumatized through the sexual abuse experience. In this reader's experience, there have been children who have been perhaps more victimized by the "system" after the abuse has been reported than they were by the abuse themselves. The reactions to abuses vary depending upon the client, their age, their intelligence, the relationship between the victim and the perpetrator, and the length of time and manner in which the abuse took place. The psychologist must not assume that there has to be a devastation upon the child. In many of the cases that this reporter has been involved in, the children seem to innately recognize that the perpetrator was at fault and that they were not to blame. They did not appear to suffer any short or long term emotional damage as a result of the abuse and as this writer has followed-up these children they seem to continue to be functioning adequately as reported by their mothers and the school situation. Therefore, it would behoove the psychologist to look for the behavioral manifestations of problems rather than assume without evidence that they are there. An example that may help the reader understand this point is a case which was presented to this author during the last year, where a step-father was systematically sexually abusing three of the female daughters in the home, ages 8, 6 and 4. In addition to personally committing sexual intercourse with the two older girls, he was also taking pictures of them in various sexual activities and selling them for pornographic purposes. When this author interviewed the girls and reviewed their school situations, it was found that the 8 year old girl had accepted the fact that her father was a sick individual and she was not experiencing any nightmares or difficulties once the father was removed from the home. The 6 year old girl, however, was having nightmares, enuresis, and was described by the school as extremely distractible and fidgety. She also had crying spells and was excessively clingy to the playground teacher during recess. The 4 year old girl did not seem to be having any difficulties that could be observed at that time. Treatment was begun with the 6 year old daughter to try to help her recognize her lack of responsibility for the acts and to assure her that she would be protected from further abuse.

For the purposes of treatment, we will assume that the child is having difficulties and that treatment is warranted. Leaman (1980) indicates that sexual abuse may be viewed in many cases as a situational crisis for the child and family. The treatment goal is the resolution of feelings about the abusive episode so that the family can return to normal functioning as soon as possible. Leaman suggests that perhaps crisis intervention techniques would be useful in helping family members cope with their immediate reactions and then perhaps ease their transition to more intensive interventions when warranted. Leaman recommends that the therapist's role in this case be active and direct and to help the family 1) gain an intellectual understanding of the event, 2) assist them in bringing their feelings into the open, 3) explore their past and present coping mechanisms, 4) find and use support systems, and 5) plan to reduce further trauma for the child and to protect them from further reoccurrence of the abuse. Leaman goes on to say that parents of a very young child or an infant might be encouraged to reduce the number of strangers who come in contact with the child and to spend more time holding and cuddling and letting the child know they're okay. In fact, she suggests that parents should be told that the child needs to have physical affection in a positive way and parental reactions of shock or horror are poor in that they may imply to the child that there is something wrong with them and they are being criticized. Sexually related questions should be answered honestly and openly although it's not necessary to give them a blow by blow description of sexual relationships. It should be remembered by the psychologist in working with families that too much information may be as confusing to a young child as too little. These children need to be reassured that they are going to be both safe and loved. With older children, Leaman suggests that parents recognize that some form of aggressive sex play may be normal and not an indication of any serious sexual problems or the beginning of any promiscuity. It may be useful in working with these children to help them work out their problems with play therapy with dolls and toys to help them understand that this is more acceptable than working them out with peers. Adolescents may need special support and consideration and the adolescent youngster must realize that they are going to be protected and loved and the best procedure may well be to keep lines of communication open. This reporter has found that in working with adolescents, the use of a group is extremely beneficial where youngsters can begin to recognize that they are not alone in their feelings and they can draw upon each other for support in helping to get over their feelings of anger, betrayal and isolation.

Sgroi (1975) indicates that as more attention is given to the area of sexual abuse and as more children become aware that they're not alone in this situation, we'll feel more comfortable in openly dealing with their particular abuse. She also indicates that the growing number of hotlines offering 24 hour service has also been a factor in increasing awareness and getting children into programs to help them overcome the impact of the sexual abuse. Giarretto (1980) clearly points out that the punitive approach to working with these families is not in the child's best interest. Giarretto points out that the criminal justice system, often seeking indisputible evidence, may descend on the child and family with terrifying force, with the resulting conclusion being that the entire family is entangled in a web of retribution. Giarretto proposes a humanistic approach to working particularly with father-daughter incest victims. He indicates that it is necessary to generate a warm, optimistic atmosphere where the family is given hope and reassured that their situation is not as devastating as they may have come to believe. The psychologist must be willing to listen to their feelings of despair, shame and guilt with compassion and be able to accept their current feelings without evaluation. This is particularly important in those psychologists who choose to work with incestuous families, for if the psychologist is projecting his or her own value structures on this family, and presenting them with reciprocal anger and revulsion, he or she is probably going to do more harm to the family, and at this point it will probably be more beneficial to the family to have a different therapist working with them. As Giarretto says, this does not mean that the psychologist must condone this incestuous conduct or even go along with pleas for mercy, but rather do not go into the therapeutic relationship feeling that the abuser is cursed or suffering from some exotic mental aberration or any other serious "sickness." Giarretto also presses the issue of personal responsibility for the incestuous behavior no matter what the extenuating circumstances may be. The mother in the family must also eventually recognize her participation in the incestuous situation, to recognize that her relationship with the husband and daughter was to a degree partially responsible for the events. In working with the child, again keeping in mind that feelings of self-blame and guilt for "endangering the family," Giarretto points out that the mother and the father must assure the girl that she was the victim of poor parenting and that they were at fault. Giarretto feels that this is important in helping the girl regain trust in the father and the mother as parents. Giarretto says an important feature of the treatment is delivered coaching and the techniques of self-awareness so that each individual can develop independently the skill of observing their own growth and that of the family. Giarretto maintains that each individual needs to learn that they can control the way they behave and ultimately the course their life can take. The marriage and the family are given purposeful direction and each individual is encouraged to develop a strong sense of self-identity and to develop a greater degree of self-esteem.

Giarretto (1981) has been instrumental in developing a very comprehensive child sexual abuse treatment program (CSATP) in Santa Clara County in California that is widely used throughout the country. CSATP is composed of three interdependent components which are professional staff, a group of volunteers, and self-help groups. Together they generate the humanistic, community-rooted climate in which the sexually abused children and their families are supported during the crisis period and go on to learn the attitudes and skills needed to develop social responsibility. The CSATP copes with all forms of child sexual abuse, both familial and extrafamilial. They deal not only with children that have been just molested, but also deal with adults who were molested as children. The professional component are officials who are members of the community such as police, social workers, mental health workers, lawyers, judges, etc. As one can see, this is an interagency cooperative program which agrees in substance on a consistent treatment approach, and works cooperatively to implement the approach. The volunteer component may be psychological interns who may perform office duties such as transporting children, or big brothers/ big sisters type programs supervised by licensed counselors and psychologists and which provide intense companionship to the new clients. The self-help component is a group called Parents United and Daughters and Sons United, who generally meet on a weekly basis and help each other by extending understanding and compassion rather than judgment and condemnation. The group also helps parents and abusers to reconstruct their anger and frustration in other directions, and not at the children. Operating somewhat like AA, the group tries to help each individual to have patience with themselves again and again by taking each day as it comes, and by recognizing that while they're human and will probably backslide at times, there will always be someone willing to listen and help. Through Parents United families can develop greater social skills and be less isolated within their communities. The daughters and sons component of the program provides a great deal of emotional support to the victims, helping them with any guilt feelings that they may have as well as helping them dealing with such destructive behaviors as running away, drug abuse, prostitution, promiscuity and possible suicide. Their goal is to break the abusive and dysfunctional pattern which is present in these families. This program has been in effect since 1971 and has been evaluated as late as 1977 with the following results being presented:

1. no recidivism with more than 250 families receiving a minimum of 10 hours of treatment and formally terminated.
2. families involved in this program have their children returned to their families sooner; 90% within the first month, 95% eventually.
3. self-abusive behavior of the children had been reduced in both intensity and duration.
4. about 90% of the marriages were saved and many confiding that the relationships were better than they were before the crisis.
5. the coordinated approach seemed to help prevent truancy, decline in school performance, promiscuity, and heavy drug use by helping girls overcome their strong feelings of betrayal and guilt. Giarretto found that of 70 incest victims, two months prior to the evaluation, only 4% had gotten drunk or high on drugs, and only 3% showed signs of sexual promiscuity. He points out that these figures are extremely low compared with other figures in the literature on sexual child abuse. Giarretto also reports that the psychological health of

> girls improved during the course of treatment, with such symptoms as bedwetting, nailbiting and fainting declining from 47% at intake to 6% by termination. The girls relationships with their peers and other family members showed marked improvement as well. In fact, the evaluation found that relationships between the daughters and the fathers improved from 22% to 50%. Evaluators determined that the overall recidivism rate for the CSATP client families was .06% compared to an average of 2% rate reported by other studies. It should, however, be pointed out, as Giarretto notes, that with or without therapy it appears that 98% of incest offenders will not repeat the offense once it comes to the attention of the criminal justice system and the family secret has been broken.

The psychologist is forewarned, however, that working with children of incest does have problems. Krieger, Rosenfeld, Gordon, and Bennett (1980) point out that many of these children coming into counseling or therapy will present a very provocative or seductive behavior. Krieger, et al. reports cases where the children rubbed against the counselor, displayed their underwear or invited them to tickle them for fun. A six year old boy referred for disruptive behavior wanted to continually fondle or touch the female counselor. Another child presented attempted to masturbate in front of the therapist and undress. The older female incest victim, age 12, seductively tried to flatter the therapist's clothing and lifestyle which gradually changed to a very angry, aggressive manner when the therapist would not participate. Another youngster presented was hyperattuned to the psychologists' needs and desires and was extremely pliant with all wishes, giving the therapist what the child perceived that was wanted rather than what the youngster actually felt. Krieger notes that children benefited from intervention as evidenced by better peer relationships, school performance and family functioning as the therapist provided a positive environment. As the psychologist and counselor did not act like the child's parents, the safe nonimpulse ridden environment was provided, and gradually the seductive behaviors disappeared. At this time, the children probably could address their more basic fears, angers and senses of self-deprivation, they were then able to begin to put things into perspective. Undoubtedly, the children were also testing the adult therapist to determine whether or not they would respond as their parents had responded to them. The anger that many of the therapists began to see, Krieger speculates, was the child's inability to trust, since their trust had been so violated by the abuser. The psychologist must recognize that the children are going to initially test them and, by recognizing this, hopefully will not in their discomfort be covertly angry at the client and distance themselves from them in taking some defensive and probably nontherapeutic techniques. Krieger also points out that due to the particular sensitivity of these children, the psychologist and therapist should be very careful about avoiding any behaviors which could possibly be interpreted as responding to the seduction. There should be no unusual surprises or granting of special privileges or lifting or not placing any limits on their behavior. Any overt response of amusement or allowing them to touch or tickle the psychologist would suggest little difference between them and the parent.

Spencer (1978) suggests that the psychologist working with the victim must convince the victim that they are committed to ending the sexual abuse. The victim must be protected and helped to feel that what happens is important because they are important. This is particularly significant since the authority figures in the youngster's life have not been trustworthy and they must be shown that some adults or that most adults can, in fact, be trusted. Spencer points out that it is absolutely critical that the victim be believed and cared about, and supported in their right to stop the sexual abusive behavior. In the past, the victim has felt powerless and will need consistent support. The victim must have the continued opportunity to express their feelings of anger, disgust and hurt towards both parents as well as the equal feelings of ambivalence and caring about the abuser. The victim must have the continued opportunity to express their feelings of guilt and responsibility to someone who sees them as worthwhile and helps them to feel worthwhile. This is important because many times the child has been labeled "bad" and the cause of the family difficulties, particularly with small children, who tend to believe what others tell them.

There is no exact treatment modality for working with children or families where sexual abuse has occurred. It is, however, critical, as Wells (1981) points out, that the family must recognize and be dealt with from a reality based approach which should stress the negative consequences of any resumption of incestuous behavior. These consequences may have to be stressed through the criminal justice system or the removal of the child from the home on a permanent basis.

Courtois and Watts (1982) point out that counselors and psychologists in working with children who have been victimized need to recognize the intense pain that can be attached to dealing with the experience both for the child and for themselves; however, they cannot afford to get bogged down (in the pain). The authors point out that to be effective in working with these children, a realistic perspective must be kept, not only in acknowledging the topic and the painful consequences but also in viewing the child as a whole person who has the strength and the survival skills necessary to resolve the experience. They point out that victims of sexual experiences may demonstrate some rather unique needs and characteristics. We must be cautious not to isolate them in any confining category, thus reinforcing their sense of being different. They further suggest, as has been previously stated, that counselors must be cautious about overexpressing their own feelings and that the counselors own anger or rage to the situation can be an additional burden to the child and can hamper the counseling situation. Timing and approach are all important and the psychologist in their endeavor to help the youngster must be careful about pushing too hard or too fast. Progress with many of these youngsters may be very slow because of the difficulty in dealing with the situation and the pain that it invokes. The authors stress the work of Forward and Buck (1978), who suggest group therapy as being useful for these children, because of the potential for the group's ability to support and identify these youngsters and suggest to each youngster the commonality of experience and pain that they are going through. They feel that this may cut through a lot of the defenses and denials that may occur, as well as providing a safe environment to try out new behaviors. Meiselman (1978) also uses a group approach with the goal being to help victims develop feelings of confidence, assertiveness, and personal responsibility.

McCarty (1981) points out that the key to successful intervention is working with the mother figure in the home. McCarty says that if the mother can be helped to believe the victim and to see that doing so will not destroy her life it may be a good step in getting her to accept responsibility for the prevention of further abuse. Generally, in most states, if the mother cooperates, the victim will not have to be removed from the home. In working with these families it is useful, as McCarty points out, to focus in on the present. It is not terribly productive to go through the situation of why didn't the mother know sooner or why didn't the child say something. Rather, the question is, do you believe the child now? McCarty suggests strong confrontation for the mother who still denies the existence of the incest. McCarty also says that the worker must be prepared to handle the mother's feelings of being betrayed by both the husband and by the child. She will definitely need help in moving from blaming the daughter to saying the daughter is the victim. McCarty also points out that in the Dallas, Texas program where she works, she has found that approximately 75% of the mothers have admitted to being sexually abused themselves as children. Helping the mother talk about her own experience may be very helpful in her being able to then support the child. Questions such as, "How did mother feel when it was happening to her?", "What threats did the perpetrator use?", "Did she tell anybody?", "Was she believed?", "Protected?", "How does she think the sexual abuse affected her life?" will allow the psychologist to empathize and show the mother, by drawing parallels to the daughter's victimization, that she can make things work out better for her child. McCarty further emphasizes the role is to provide hope that the situation can get better by counseling the mother as to what kinds of things that she needs to say and do to begin to repair the damage. Perhaps the best way to start is the apology to the daughter for not believing or protecting her and assurances that she will protect her now. Psychologists can be very helpful in assisting the family in getting what treatment resources that are available and assuring that they will help the entire family get the help that they need.

Simari and Baskin (1979), in a paper presented to the American Psychological Association, noted psychologists can be extremely helpful in working with these children by being able to provide accurate follow-up information from schools and helping to develop community resources and support systems. The authors also point out that blame should never be focused on any single family member, including the offender. This does not mean that responsibility should not be assumed by the perpetrator and the family because the entire family system shares responsibility in the dysfunction of the system. Simari and Baskin offer some suggestions as to when family therapy or treatment may not be particularly useful, as where there is unwillingness of the perpetrator or other family members to participate in any therapy or to get them to do so on a consistent basis, or when the nonoffending parent becomes aware of incest and punitive retaliation against the child may occur.

Pittman (1977) points out that social agencies may make the assumption that separating the child from the family or from the perpetrator may be the solution to the problem. Pittman feels that separation is never a substitute for treatment and if separation is necessary, the family members should be reunited as soon as possible.

Watts (1978) suggests that treatment should be based on the issues raised by the nature of the sexual assault and the victims' response pattern, e.g. express, control, silent, compounded. She also suggests that the counselor behaviors that are most likely to facilitate counseling are acceptance, understanding, nonjudgmentalness, support, optimism and compassion. Watts suggests that perhaps gestalt exercises can encourage the identification of feelings, body awareness, and an expression of those feelings. She also suggests the use of guided imagery to help the client or child integrate thoughts and feelings in the present. Other useful questions that Watts suggests are questions such as asking the client, "What has it been like to keep a secret like this for such a long time?" Or by asking them if they had talked about the problem with anyone previously and what response they received from significant others to whom they reported the abuse. She also suggests the counselor make an attempt to assess and understand what coping strategies that the victim chose and is now choosing as a result of their experience. Psychologists can then help the child identify what conflicts or feelings they wish to resolve or behavior they wish to change in order to achieve a more adaptive lifestyle. Watts reminds the counselor to remember that children usually are not educated as to what their resources are and see themselves as having nowhere to go outside of the family, with no options, choices, and certainly no power. Therefore questions such as, "Why didn't you do something?" are usually reinforced to the child that somehow they are responsible for allowing the situation to occur and are certainly not effective questions. Psychologists must keep in mind that the parent and child are unequal and different and the child cannot be a full and consenting partner in a sexual relationship.

Siegel (1980) suggests that in working in groups with adolescent girls, psychologists should keep in mind that these youngsters do not know how to get someone to care for them in other than a sexual way and that they often tie their sense of worth to their value as sex objects. Therefore, the goal of treatment should be in getting the youngsters to see themselves valuable as people and not for simply the value as gratification for others. Siegel also points out that having a group experience where adolescents can share this common experience helps them recognize that they were not the only ones who were sexually abused and can help increase their faltering self-esteem. Sigel also points out difficulties that he noted with work in groups for both male and female psychologists or counselors.

Girls may rebel against the norms set by the female psychologist as a demonstration of the anger at their mothers for not protecting them and often feeling that the mothers either actively colluded with the father figure or denied evidence that the incest was occurring and did nothing. With the male figures, as previously stated, they may appear very seductive and very uninvolved with the female coleader of the group. Siegel suggests that after the initial need to talk about their specific experiences and current circumstances is completed, the group may get involved in a lot of defenses of denial and rationalization and try to focus in on others rather than themselves and, at that point, increasing confrontation may be necessary in order to get them to deal with the more significant conflicts within them. Siegel uses interns occasionally to work with the girls in nonthreatening settings, such as going out to eat or riding bicycles which they felt increased the openness of the group and allowed it to convey the fact that a relationship can be developed with a caring adult that is not sexually motivated.

Brickman and Haus (1977) feel that one of the primary problems in sexual abuse with female children is the development of sex role stereotypes which seem to set up children to be victimized. Brickman and Haus suggest that even in school if either gender tries to experiment with the other's role they are quickly directed back to their appropriate roles and if they persist they are considered "deviant" for particular behaviors and characteristics that are not considered desirable. They found that the three preferred attributes for females and primary school children were: 1) less noisy and dirty than boys, 2) obedient, and 3) helpful. The authors point out that the issue of acceptance based upon desirability is a primary variable in the development of self-concept and, in essence, the self-concept is a function of social acceptance. Therefore, in treatment, the father, the mother and the daughter will all need to cooperate in role-rearrangement so that the child does not perceive her social acceptance based upon her willingness to acquiesce to abuse. The authors believe that incest is utilized to reduce family tension by preventing confrontation with the source of tension and that preservation of the family group is the central function of the incestuous relationship and the daughter has simply assumed the role to maintain the structure of the family which the mother has abdicated. By changing the youngster's perception of her role, the role will become redefined, and performance would have to come from another member of the family unit. Therefore, the equilibrium of the family is changed and redirected to a more healthy outcome.

When the psychologist becomes involved in the evaluation and treatment of a sexually abused youngster, at some time in the process he/she may well be asked to present evidence to the Department of Human Services and/or the court system regarding the disposition of the case and whether or not the youngster or the father, depending upon the situation, should be returned to the family. This is always a difficult question to answer and the critical determiner should be whether or not things have sufficiently changed within the family and whether the child is likely to be protected from any additional or further abuse. Server and Janzen (1982) suggest the following criteria be used as guidelines for reconstituting the family:

1. if the father has acknowledged responsibility for the sexual abuse and does not project blame onto the daughter.
2. the therapist and all family members express reasonable assur-ance that the child is going to be protected from further abuse. 3. the daughter demonstrates the ability to seek help in the event that she is again approached.

4. the mother demonstrates a greater ability to protect the children and herself from abuse.
5. the therapist and family members are confident that progress has been made toward the resolution of the short term and long term goals.
6. the mother-daughter relationship has improved and the mother does not hold the child responsible for the molestation.
7. the generational boundaries have been strengthened, resulting in more appropriate family roles and a better marital relationship.

Server and Janzen suggest that the child will continue to be at risk when any of the following conditions persist:

1. the child is not believed by the mother.
2. the father continues to deny the abuse ever took place.
3. the nonabusing parent is unable to protect the child from repeated assault and there is a decided lack of motivation on the part of the family to work towards any change in the family system.
4. when the offender does not seem to be able to emphathize with the child at all or to comprehend what the detrimental effects of the child abuse are.
5. when the maternal figures own needs are such as to make her aline with the abuser and will interfere with her capacity to relate positively and protect the child.

In these cases, difficult as it might be, it might be in the child's best interest to remove them from the home, continuing to assure them that this is necessary for the time being to assure their safety and to protect them from further abuse.

Gruber (1981) suggests that the child's need for affection may unintentionally invite the sexual contact. This would suggest that one of the primary focuses that the school psychologist may wish to employ in working with the child victim is to help them recognize alternative ways of getting affection and nurturance without allowing themselves to be victimized by those who would take advantage of this need. Children can be taught effective ways of getting attention, affection and recognition without allowing themselves to be sexually exploited. These procedures can be done in both individual and group therapy so that the child can learn how to become less vulnerable to abuse.

Justice and Justice (1984) feel that in the treatment of incestuous families it is essential to have judicial leverage. In the families that they work with, virtually all of the parents came under legal duress. Justice and Justice feel that given the nature of distrust in these families and their social isolation, without some outside pressure forcing treatment upon them they would virtually never seek help. They recommend that civil proceedings, through the Department of Human Services, be used when possible, with the threat of criminal sanctions being used as a "leverage." Their treatment of families, usually only the parents and the victim-child are included in the sessions. The purpose of the family sessions is to get them to acknowledge that the parents, and not the child, are responsible for the problem. Even if the parents refuse to admit that the incest has occurred, Justice and Justice recommend confrontation with the parents to assure them that it is *their* responsibility. This point is emphatically shared with the child so that they are continually reinforced that it is not their fault and that the parents will go for help to see that the problem does not continue. While the authors recognize that parents will occasionally sabotage treatment, they feel that it is reassuring for the child to hear at least one adult absolve them from the responsibility and to indicate to them that they are believed. The authors maintain that there is a much greater risk in not believing the child who is telling the truth than in believing the child who is not telling the truth.

Justice and Justice use a goal attainment scale in their counseling which is used both therapeutically and as a means of evaluating results. The typical problems worked on are the symbiotic relationship with the child, the marital relationship, stress reduction, sexual climate between the parents and the feelings of isolation. Usually contracts are made under each area for three month periods of time and at the end of that time results are evaluated to determine to what degree goals have been met. Justice and Justice found that the average length of time in treatment was six months although some stayed longer than one year. Changes brought about by the program that were deemed successful were 1) parents learned to turn to each other for support and nurturing instead of the child, 2) parents learned to ask for what they needed instead of forcing others to take care of them, 3) both the father and the mother began practicing stress management techniques, 4) sexual climate in the home changed to be more appropriate, 5) the isolation of the family was reduced as they learned to reach out and to make new friends, and 6) in families where drinking was a problem, it ceased to be one. Most importantly, they found that the daughter was allowed to be a child in the family instead of a caretaker for the parent. Interestingly, the Justices point out that as a result of the problem coming to social recognition and the therapy, that marriages of the couples were strengthened rather than weakened. The authors report that the parents said their sexual activity increased in frequency and in quality, and the fathers' sense of his own sexual good health was also markedly improved. There was also much less arguing in the family and, by and large, the total family's mental health was improved.

In this author's opinion results of this nature are very useful, and suggest to the child that by telling or sharing that they are being sexually used, the probability is that it is going to help the family, and that everyone will ultimately be happier.

EDUCATIONAL PROGRAMS FOR PREVENTION

During the last several years, many programs have been developed and are currently available for use with children in preventing sexual abuse. In this section of the chapter, programs that have been evaluated will be presented as will the highlights of their presentations. It is this authors opinion that school psychologists can be of immeasurable assistance in helping children prevent sexual abuse by helping to develop and implement programs on sexual abuse so that children recognize their own victimization and how to prevent it. The psychologist should keep in mind, as Giarretto (1981, p. 196) stated, once the family secret is broken and the children learn to talk about child abuse about 98% of the incest and child abuse can be prevented. As Nicholas Groth (1978, p. 4) and Linda Sanford (1980, p. 266) have indicated, the goals of an educational program should be to alert children to the risks of being a victim and to teach them how to handle such situations. They should be taught how to be assertive with an adult, and they should be knowledgeable of their rights and the risks others may be to them. Children need to learn that people do not have the right to touch children's bodies in personal and private areas or to ask children to touch them in such places or to expose themselves in the presence of children. Children need to learn that they need to be suspicious of anyone (a relative, friend, acquaintance, or any stranger) who permits or encourages them to do things that their parents do not approve of. Both of these authors point out in teaching the child about victimization, sex is really neither presented as bad or good but that exploitation, deception, trickery, betrayal of trust, and taking advantage of someone else is wrong, whether this occurs in a sexual or a nonsexual way. They further point out that the child isn't wrong for trusting or obeying an adult or for cooperating with what the adult demanded of him or her and that the child is not to be blamed. They should be taught in the program that sex is not bad but it is not proper for a grownup to take advantage of a child sexually.

In addition to the child sexual abuse treatment program of Santa Clara County in California, already reported on in this chapter, there are several other programs of worthy note. Ronald LaTorre (1982) discusses an evaluation of a personal safety project conducted in the Vancouver, British Columbia Public Schools. The program was presented to teachers, parents, and children. These presentations were all done separately. Results of the program (which dealt with the entire scope of sexual abuse in terms of statistics and myths for parents and teachers, and a touch program for children) suggested that parents indicated a greater likelihood of believing the children's complaints of sexual misuse and a greater ease in discussing sexual topics at home after attending the workshop. First and fifth graders were examined for their ability to terminate a discomforting touch and it was found that all fifth graders who attended the program were able to do so successfully. However, only 1 out of 10 first graders successfully were able to do so. Students showed an improved awareness of potentially dangerous situations, indicated that they valued their bodies more, and demonstrated greater self-esteem after the program. Observed behavior problems also decreased for the intermediate students and remained constant for primary students after the program. Teachers also felt more comfortable about discussing sexual misuse in class after participating in the workshop. One of the sets of materials that were used in this program was the "Red Flag, Green Flag People" (Williams, 1980), which is a coloring book and questionnaire for children which helped them identify touches which made them feel good or bad or confused. The results of this program suggest that perhaps asking first graders to take responsibility for terminating difficult situations may be asking a great deal and perhaps greater intensity of programming will be necessary with this age group.

Brassard, Tyler, and Kehle (1983) describe the results of the You're In Charge program which is presented to children in a video format designed for classroom use. Two person teams, generally a male and a female that can be made up of either local PTA, community leaders, psychologists, social workers, etc., present roleplays and discussions that are adapted to the developmental level of the viewing students. The program is based on the idea that children are going to be far less able to be exploited if they know some factual information and are given an opportunity to discuss their feelings in a supportive environment. The main points of the You're In Charge program is:

1. that the child's body is their own property and no one has the right to hurt them or do anything to make them uncomfortable or afraid no matter how well you might know that person.
2. that parents or other significant adults need to be informed immediately if anyone or any situation makes them uncomfortable or afraid.
3. that children should obey common sense safety rules such as using going with a friend when walking about the community and not accepting rides from people without permission from the parents.

In addition to the program for the children there is a presentation for parents which stresses the importance of providing children with information and that teaches parents that children have to know how to say no to friends or family members if someone says or does something to them to make them uncomfortable. Children are also provided with simple instructions for actions to take if sexual abuse has occurred as well as with a list of local support agencies that they can call to report the abuse to and from whom they can receive help. In addition to this, parents are also taught to speak to their children about touch and are taught to distinguish between normal sexual exploration among children and how it differs from inappropriate touch from fathers and other family members. The program was evaluated by the Utah State Office of Education, utilizing three school districts and 13 schools. While the evaluation does not indicate how many children came forward as a result of the program, or how much abuse was stopped, the Utah State Department did conclude that the program had a significant positive impact on student knowledge in the area of prevention of sexual abuse. The authors do point out that while the program is designed for use with elementary school children, it is just as effective when presented to secondary children. Authors also point out that while the touch program is often done by an acting troup, an alternative approach is to show films on the subject followed by classroom discussion. The authors mention films that they found appropriate such as the "Speak Up! "Say No!" cartoon filmstrip for preschool and kindergarten age children and the "Child Molestation, When To Say No" for elementary aged children. For adolescents, they recommended that the touch program and the film, "Incest, The Hidden Crime," and "Child Sexual Abuse: The Untold Secret" which is a videocassette designed particularly for junior and senior high school students.

Severns (1983) developed a program which had the intent of informing children on sexual abuse within the context of good and bad touch and, through the use of "What if..." situations giving children instruction for self-protection and opportunity to practice these skills. Additional components of the program were instruction in self-assertiveness and how to tell an adult "No," information for school personnel about sexual abuse and the available community resources, and information for parents and opportunities for parent participation. Severns developed materials for children in kindergarten through third grade (games and roleplaying activities) and fourth through sixth grade (filmstrips on self-protection). Issues related to child sexual abuse programs that Severns has provided seem useful and she presents, in her appendix, a listing of the materials she utilizes. Severns goes on to indicate that after discussing the differences between good and bad touch children report having more permission to touch, more permission to ask about confusing touch, and more feelings of acceptability to say no to touch they do not want. She also indicates the older the students are, the higher the likelihood that they will have more taboos and fears around touching and the program has been successful in giving them more freedom to protect themselves. Severns does, however, go on to say that it is difficult to truly evaluate the effectiveness of a primary prevention program since sexual abuse is highly underreported and it will not be possible to conduct large scale and long range studies of populations of students who have received preventative education until there are a lot more of these students and they are systematically followed-up.

A program that has received wide acclaim is the Illusion Theater in Minneapolis, Minnesota. Rosenzweig (1984) discusses the Illusion Theater which essentially is a program presented to schools by actors and actresses which demonstrates to children the continuum of touch. It teaches them there is good touch and bad touch and children can sense the difference. The children learn that they do not have to accept the bad touching and parents are taught that children should be allowed to make their own decisions about whom to touch and should be discouraged from forcing a child to hug or kiss people if they do not want to. Illusion Theater has a guidebook for developing curriculum for children and can be adapted for use by a school system but does require actors and actresses to put on the program. Although there is no data in the outcome of this program, it is reported to be viewed by districts who have seen it as highly successful and effective in helping children come forward to discuss sexual abuse.

An additional curriculum which this writer is familiar with and is highly recommended is the Personal Safety Program (1984), a curriculum for prevention of child sexual abuse developed by Marlys Olson in Tacoma, Washington. The strength of this curriculum is that it is a set of six distinct curriculums ranging from the preschool level through high school. This curriculum is complete with activities, questionnaires, and rationale. It has been used widely by the Tacoma Schools and provides a readily accessible program for teachers, psychologists and others who would like to become involved in helping children develop personal safety. The activities are especially good, and filmstrips can be adapted to fit the activities included in the program.

Plummer (1984) has developed a curriculum which is also quite good for youngsters from grades kindergarten through twelfth and special education populations. In this program are many activities and strategies for all types of professionals that are working with children and it is set up so that a program can be done in a three or five day presentation. Pre and post tests are included, as well as suggestions for working with parents and outside community resources.

The interested reader is also referred to the Curriculum on Child Abuse and Neglect published by the Department of Health Education and Welfare (1979) under the title, "We Can Help." This two-volume set includes a resource book as well as a leader's manual and is designed to help children identify and deal with virtually all areas of child abuse with a specific section dealing with sexual abuse. While not nearly as comprehensive as the above mentioned programs it does, nonetheless, give the basic fundamentals of prevention to children and while specific curriculum in terms of goals and objectives are not included, the general ideas are present and can be adapted to individual needs and desires.

This psychologist has had wide experience with using the "My Very Own Book About Me" Program developed by the Lutheran Social Services of Spokane, Washington (1982). In the programs presented by this author and his Child Support Team, it has been found that the program works extremely well with elementary grade students. The program is excellent in that it provides each youngster with a book of their own which they can color in and solve problems in. In addition to the student book it comes with a parent guide, a teacher's guide and a therapist's guide. This would allow for a well integrated program that all members of the child's support system can be involved in to help the child learn how to protect themselves from abuse. The primary focus in the program is the issue of touch and the program, which borrows from Cordelia Anderson Kent in the Illusion Theater already referenced in this chapter, teaches kids how to identify touch, how to deal with problem situations that are presented, and then allows for discussion of the problems in a group situation. Preliminary data obtained from students after the program has found that students feel much more comfortable in recognizing their right to say no and in identifying people they can go to should they have a (touching) problem. Because of the nature of the program and its lack of specific focus on sexual issues, the program has been widely accepted by teachers and parents and there is yet to be a program presented that parents have not been invited to and have felt comfortable with upon feedback. Preliminary results obtained from the Department of Human Services, as well as school principals and teachers, have also indicated that following the conclusion of these programs many children have come forward and shared secrets about abuse with people in their support systems. It is also felt that the program is relatively inexpensive and can be easily learned and put on by people with very little training in the area. The program also comes with an optional videotape to further demonstrate how the program can be used both with parents as well as within the schools.

The National Education Association is also reported to be in the process of making a child abuse kit available to teachers in the American public schools and while this reporter has not seen this material, psychologists are strongly encouraged to obtain this kit to see how it could be best implemented in working with youngsters in the public schools.

The psychologist who wishes to become involved in a prevention/intervention program in the public schools would be encouraged to follow the following steps.

1. Talk over the problem with community leaders and community groups such as Rotary, Lions, etc. It has been found that when the community is involved in the program it is much more likely to be successful.
2. Present public awareness programs, perhaps utilizing local television or radio stations as ways of communicating to the public the need for such programs of both prevention and intervention. Keep in mind that many people are unfamiliar with or unaware of the extent of the problem and we must first make them cognizant that a need is present before we proceed.
3. Provide an inservice program for local school teachers and administrators. Teachers also need to be educated as to the extent of the problem and what signs they should be looking for in the classroom. Teachers will come with varying degrees of comfort with the subject area and it would be of tremendous assistance if the psychologist were able to reduce the teacher's anxiety concerning the sexually abused child and the reporting process.
4. Inform the teachers of the nature of the program you propose to use and, where possible, encourage the teachers to participate with their youngsters in the program so that they will be better prepared to answer questions about what has occurred. Encourage the parents to participate with the children so they also would have the opportunity to see what is going on and how they can be of help to their children.
5. Be prepared and willing to do follow-up with classes or teachers who wish additional support in helping children who have been identified and are in need of some service.
6. Try to enlist the help of the agencies which are working with children in the local area such as the Mental Health Center and the Department of Human Services. Once these children and families have been identified it is critical that there be some assistance available for them to resolve the difficulties that have developed. School psychologists may be a useful and invaluable liaison in getting these programs instituted and making school personnel and youngsters aware of them.

Monitoring Methods

As stated previously, sexual abuse is not easy to determine. Likewise, assessing the impact of intervention will have to be done through a behavioral system as well. Perhaps the best way to monitor the behavior is by tracking the child through the public school system to determine whether or not the behaviors that occurred prior to intervention are still occurring and if so in what frequency, intensity and duration. The effectiveness of prevention programs are easier to monitor in that pre and post test questionnaires can be given to the youngsters to assess their level of information and their willingness and ability to utilize support systems. A copy of such a questionnaire is included in Appendix B of this chapter.

Another way of conducting a follow-up is through behavior rating scales filled out either by the parents and/or by the schools to again assess the ongoing nature of the youngsters difficulty in handling what has occurred to them.

An excellent monitoring method is the self report. The psychologist should be cognizant that the child may not be entirely honest in reporting further abuse. This may be due to the disruption caused to the family constellation by the first disclosure, or fear of the possible removal of the victim or parent from the family.

Conclusions and Considerations

It is clear from the data that is available in the literature that child sexual abuse is one of the most widely written upon topic dealing with children today. It is certainly a critical area which impacts significantly on the lives of many children and far into their adult futures. It is, however, not an area which every psychologist should eagerly become involved. Psychologists who, for whatever personal reasons, are extremely uncomfortable dealing with sexual issues and sexually dysfunctional families should not become involved in the treatment of children who have been sexually abused. They would be encouraged to become familiar with methods of identification but, at the same time, should be willing to refer these children to those individuals who by training, experience and interest can be effective in working with these families. The school psychologist can be extremely helpful to these children in developing and getting programs for prevention underway because, as previously stated, once children know that they do not have to be exploited and develop the skills to tell an abuser "no," that often the abuse will stop.

Psychologists should be aware that not all communities or schools will eagerly embrace the notion of doing child sexual abuse prevention projects, mainly because their discomfort level or community sense of "what is right and wrong" will not permit such a program to be done. The psychologist should not lose heart in this situation, but should work carefully and patiently with community leaders, including the church groups, so that community support can be developed for such a program.

The psychologist should also accept that at the initial phase of the evaluation/treatment process it is difficult to ascertain exactly what the final impact of sexual abuse will be on any particular child. As with most psychotherapies, there is no single therapy which is the best. The effectiveness will be determined by the nature of the relationship between the psychologist and the student and how accepting and nonjudgmental that psychologist can be.

The school psychologist, in evaluating children for learning and/or behavioral problems, should keep in mind that many of these children may be in fact victims of sexual abuse. The list of indicators previously reported should serve as a guideline for psychologists to consider when evaluating these children. The psychologist must keep in mind that no symptom in and of itself is a definitive statement proving sexual abuse; however, when clusters of the behaviors begin to show up, the psychologist should at least give some consideration to that possibility.

The psychologist would also be well advised to explore the treatment options in their local community and area so that they can be of service in directing parents to individuals who can assist them in dealing with their familial problem.

While the primary focus of this paper has been on the female victim of child sexual abuse, psychologists should also realize that one boy in nine also is the victim of sexual abuse and it is probably a greater percentage than that. Therefore, they should not discount this possibility in evaluating young males as well. In this author's experience, one of the primary concerns of boys who have been victimized is the concern that they will become homosexual. Psychologists would be well advised to explore this concern with children if they will work with them in a treatment program, and help them put their fears to rest concerning their extremely remote probability of becoming homosexual as a result of a sexual abuse.

The school psychologist working with the male victim of sexual abuse will probably have a more difficult time with this youngster. Nasjleti (1980) found that boys present a consistent pattern of extreme resistance to discussing their molestation experiences. He reports that most of the boys wanted to "just to forget it ever happened." Even though they were repeatedly assured they had done nothing to be ashamed of, most of the boys refused to discuss their feelings. Even when in therapy, the majority also refused to deal with sexual abuse experiences. The sex of the therapist apparently had no effect on this attitude. As Nasjleti indicated, probable cause of this situation is that in our society males are often denied the right to be dependent on others, to be spontaneous in the expression of feelings, being passive towards aggressiveness or being allowed to ask for nurturance. Nasjleti says that the results of this have been that their feelings of fear, vulnerability, and helplessness have gone unmet, and these youngsters have suffered in silence. In short, they are socially taught that being a victim is not being masculine and so they are not (allowed) to admit being in situations over which they had no control. The author also suggests that boys, as girls, feel that reporting their sexual victimization may mean risking their safety and well being, so they often wait until they're adolescents, when they feel less physical vulnerable to disclose what has occurred. Boys also tend to feel that no one will believe them since they think that it is so uncommon, that such a report would be difficult to accept. They also assume that because most of the media coverage is focused on females, that if he discloses the event, that people will feel that he is either homosexual or that he is simply not masculine, and is thus, abnormal. What psychologists need to relate to these youngsters is that needing affection and nurturing, as well as having feelings of dependency, fear, vulnerability and helplessness, are very normal and one's maleness is not contingent upon one's physical attributes or aggression. Psychologists also need to become involved in public information programs to teach schools, as well as parents, that boys can be abused and, as with girls, they had very little choice in the matter and were unable, either through fear or lack of education, to prevent the abuse.

Finally, the psychologist again is reminded that not every child who has been victimized needs intervention. Only by careful observation of a behavioral nature, as well as by self-disclosure statements on the part of the student, can one determine whether or not the youngster is in need of some services to help them sort out the events in their life.

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Appendices

APPENDIX A

CHAPTER 709

SEXUAL ABUSE
(RAPE)

Referred to in §232.68, 701.1

Chapter 709, Code 1977, repealed by 66GA, ch 1245(4), §526; see §714.1 to 714.5 and 808.12

709.1 Sexual abuse defined.
709.2 Sexual abuse in the first degree.
709.3 Sexual abuse in the second degree.
709.4 Sexual abuse in the third degree.
709.5 Resistance to sexual abuse.
709.6 Jury instructions for offenses of sexual abuse.
709.7 Detention in brothel.
709.8 Lascivious acts with a child.
709.9 Indecent exposure.
709.10 Cost of medical examination in crimes of sexual abuse.

709.1 Sexual abuse defined. Any sex act between persons is sexual abuse by either of the participants when the act is performed with the other participant in any of the following circumstances:

1. Such act is done by force or against the will of the other. In any case where the consent or acquiescence of the other is procured by threats of violence toward any person, the act is done against the will of the other.
2. Such other participant is suffering from a mental defect or incapacity which precludes giving consent, or lacks the mental capacity to know the right and wrong of conduct in sexual matters.
3. Such other participant is a child. [C51, s2581, 3583; R60, s4204, 4206; C73, s3863; C97, s4756, 4758; C24, 27, 31, 35, 39 s12966, 12957; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s698.1, 698.3; 66GA, ch 1245(1), s901]

Definition of "sex act," 702.17.

709.2 Sexual abuse in the first degree. A person commits sexual abuse in the first degree when in the course of committing sexual abuse the person causes another serious injury.

Sexual abuse in the first degree is a class "A" felony. [C51, s2581; R60, s4204; C73, s3861; C97, s4756; C24, 27, 31, 35, 39, s12966; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s698.1; 66GA, ch 1245(a), s902]

Definition of forcible felony, 702.11.

Eligibility for deferred judgement, deferred sentence, suspended sentence, 907.2.

709.3 Sexual abuse in the second degree. A person commits sexual abuse in the second degree when the person commits sexual abuse under any of the following circumstances:

1. During the commission of sexual abuse the person displays in a threatening manner a deadly weapon, or uses or threatens to use force creating a substantial risk of death or serious injury to any person.
2. The other participant is under the age of twelve.
3. The person is aided or abetted by one or more persons and the sex act is committed by force or against the will of the other participant.

Sexual abuse in the second degree is a class "B" felony. [C51, s2581; R60, s4204; C73, s3861; C97, s4756; C24, 27, 31, 35, 39, s12966; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s698.1; 66GA, ch 1245(1), s903]

Definition of forcible felony, 702.11.

Eligibility for deferred judgement, deferred sentence, suspended sentence, 907.2.

709.4 Sexual abuse in the third degree. Any sex act between persons who are not at the time cohabiting as husband and wife is sexual abuse in the third degree by a person when the act is performed with the other participant in any of the following circumstances:

1. Such act is done by force or against the will of the other participant.
2. The other participant is suffering from a mental defect or incapacity which precludes giving consent, or lacks the mental capacity to know the right and wrong of conduct in sexual matters.
3. The other participant is a child.
4. The other participant is fourteen or fifteen years of age and the person is a member of the same household as the other participant, the person is related to the other participant by blood or affinity to the fourth degree, or the person is in a position of authority over the other participant and used this authority to coerce the other participant to submit.
5. The person is six or more years older than the other participant, and that other participant is fourteen or fifteen years of age.

Sexual abuse in the third degree is a class "C" felony. [C51, s2581, 2583; R60, s4204, 4206; C73, s3861, 3863; C97, s4756, 4758, C24, 27, 31, 35, 39, s12966, 12967; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s698.1, 698.3;

66GA, ch 1245(a), s904; 67GA, ch 147, s12, ch 1029, s47,48].

Definition of forcible felony, 702.11.

Definition of sex act, 702.12.

Eligibility for deferred judgement, deferred sentence, suspended sentence, 907.2.

709.5 Resistance to sexual abuse. Under the provisions of this chapter it shall not be necessary to establish physical resistance by a participant in order to establish that an act of sexual abuse was committed by force or against the will of the participant. However, the circumstances surrounding the commission of the act may be considered in determining whether or not the act was done by force or against the will of the other. [66GA, ch 1245(a), s905]

709.6 Jury instructions for offenses of sexual abuse. No instruction shall be given in a trial for sexual abuse cautioning the jury to use a different standard relating to a victim's testimony that than of any other witness to that offense or any other offense. [66GA, ch 1245(a), s906]

709.7 Detention in brothel. Any person who, by force, intimidation, or false pretense entices another who is not a prostitute to enter a brothel with the intent to cause such other to become an inmate thereof, or who detains another, whether a prostitute or not, in any brothel, against the will of such other, with the intent that such other engage in prostitution therein, commits a class "C" felony. [C51, s2713; R60, s4355; C73, s4016; C97, s4942; S13, s4944-j; C24, 27, 31, 35, 39, s13180, 13181; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s724.8, 724.9 66GA, ch 1245(a), s907]

709.8 Lascivious acts with a child. It is unlawful for any person eighteen years of age or older to perform any of the following acts with a child with or without his or her consent unless married to each other, for the purpose of arousing or satisfying the sexual desires of either of them:

1. Fondle or touch the pubes or genitals of a child.
2. Permit a child to fondle or touch his or her genitals or pubes.
3. Solicit a child to engage in a sex act.
4. Inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort on him or her.

Any person who violates a provision of this section shall, upon conviction, be guilty of a class "D" felony.]S13, s4938-a; C24, 27, 31, 35, 39, s13184; C46, 50, 54, 58, 62, 66, 71, 73, s725.2; C75, 77, s725.10; 66GA, ch 1245(1) s908]

Definition of sex act, 702.17.

Referred to in 907.3.

709.9 Indecent exposure. A person who exposes his or her genitals or pubes to another not his or her spouse, or who commits a sex act in the presence of or view of a third person, commits a serious misdemeanor, if:

1. the person does so to arouse or satisfy the sexual desires of either party; and
2. the person knows or reasonably should know that the act is offensive to the viewer.]66GA, ch 1245(1), s090; 67GA, ch 147, s13]

Definition of "sex act," 702.17

709.10 Cost of medical examination in crimes of sexual abuse. The cost of a medical examination for the purpose of gathering evidence and the cost of treatment for the purpose of preventing venereal disease shall be borne by the state department of health. [66GA, ch 1245(a), s910]

Appropriation, 67GA, ch 1008, §1

CHAPTER 710

KIDNAPPING AND RELATED OFFENSES

Referred to in §^{s}701.1

Chapter 710, Code 1977, repealed by 66GA, ch 1245(4), ^{s}526; see ^{s}714.1 to 714.3

710.1 Kidnapping defined.
710.2 Kidnapping in the first degree.
710.3 Kidnapping in the second degree.
710.4 Kidnapping in the third degree.
710.5 Child stealing.
710.6 Violating custodial order.
710.7 False imprisonment.

710.1 Kidnapping defined. A person commits kidnapping when he or she either confines a person or removes a person from one place to another, knowing that he or she has neither the authority nor the consent of the other to do so; provided, that to constitute kidnapping the act must be accompanied by one or more of the following:

1. The intent to hold such person for ransom.
2. The intent to use such person as a shield or hostage.
3. The intent to inflict serious injury upon such person, or to subject the person to a sexual abuse.
4. The intent to secretly confine such person.
5. The intent to interfere with the performance of any government function. [C51, s2588; R60, s4211; C73, s3869; C97, s4765; S13, s475C-b; C24, 27, 31, 35, 39, s12981, 12983; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s706.1, 706.3; 66GA, ch 1245(a), s1001]

710.2 Kidnapping in the first degree. Kidnapping is kidnapping in the first degree when the person kidnapped, as a consequence of the kidnapping, suffers serious injury, or is intentionally subjected to torture of sexual abuse.

Kidnapping in the first degree is a class "A" felony. [C51, s2588, R60, s4211; C73, s3869; C97, s4765; C24, 27, 31, 35, 39, s12981; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s706.1; 66GA, ch 1245(a) s1002]

Definition of forcible felony, 702.11.

Eligibility for deferred judgment, deferred sentence, suspended sentence, 907.2.

710.3 Kidnapping in the second degree. Kidnapping where the purpose is to hold the victim for ransom or where the kidnapper is armed with a dangerous weapon is kidnapping in the second degree. Kidnapping in the second degree is a class "B" felony. [C51, s2588; R60, 4211; C73, s3869; C97, s4765; S13, s4750-b; C24, 27, 31, 35, 39, s12981, 12983; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s706.1, 706.3; 66GA, ch 1245(a), s1003]

Definition of forcible felony, 702.11

Eligibility for deferred judgment, deferred sentence, suspended sentence, 907.2.

710.4 Kidnapping in the third degree. All other kidnappings are kidnappings in the third degree. Kidnapping in the third degree is a class "C" felony. [C51, s2588; R60, s4211; C73, s3869; C97, s4765; C24, 27, 31, 35, 39, s12981; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s706.1; 66GA, ch 1245(1), s1004]

Definition of forcible felony, 702.11.

Eligibility for deferred judgment, deferred sentence, suspended sentence, 907.2.

710.5 Child stealing. A person commits a class "C" felony when, knowing that he or she has no authority to do so, forcibly or fradulently takes, decoys, or entices away any child with intent to detain or conceal such child from its parents or guardian, or other persons or institution having the lawful custody of such child, unless the person is a relative of such child, and the person's sole purpose is to assume custody of such child. [S13, s254-a46; C24, 27, 31, 35, 39, s12982, C46, 50 54, 58, 62, 66, 71, 73, 75, 77, s706.2; 66GA, ch 1245(a), s1005]

710.6 Violating custodial order. Any relative of a child who, acting in violation of any order of any court which fixes, permanently or temporarily, the custody of such child in another, takes and removes such child from the state, and conceals the child's whereabouts without the consent of the person having lawful custody, commits a class "D" felony.

Any parent of a child living apart from the other parent who takes and conceals that child from another within the state in violation of a custodial order and without the other parent's consent shall be guilty of a serious misdemeanor.

CHAPTER 235A

ABUSE OF CHILDREN
(PHYSICAL)

Referred to in §232.2, 232.96

235A.1 to 235A.11 Transferred to §232.67 to 232.77.

CHILD ABUSE INFORMATION REGISTRY

235A.12 Legislative findings and purposes.
235A.13 Definitions.
235A.14 Creation and maintenance of a central registry.
235A.15 Authorized access.
235A.16 Requests for child abuse information.
235A.17 Redissemination of child abuse information.
235A.18 Sealing and expungement of child abuse information.
235A.19 Examination, requests for correction or expungement and appeal.
235A.20 Civil remedy.
235A.21 Criminal penalties.
235A.22 Education program.
235A.23 Registry reports.
235A.24 Council on child abuse information.

§s235A.1 to 235A.11 Transferred to §232.67 to 232.77; see 67GA, ch 1088, §102.

CHILD ABUSE INFORMATION REGISTRY Definitions applicable to this division, see s232.68.

235A.12 Legislative findings and purposes. The general assembly finds and declares that a central registry is required to provide a single source for the state-wide collection, maintenance and dissemination of child abuse information. Such a registry is imperative for increased effectiveness in dealing with the problem of child abuse. The general assembly also finds that vigorous protection of rights of individual privacy is an indispensable element of a fair and effective system of collecting, maintaining and disseminating child abuse information.

The purposes of this section and sections 235A.13 to 235A.24 are to facilitate the identification of victims or potential victims of child abuse by making available a single, state-wide source of child abuse data; and to provide maximum safeguards against the unwarranted invasions of privacy which such a registry might otherwise entail. [C75, 77, s235A.12]

Referred to in §§ss235A.13, 235A.24.

235A.13 Definitions. As used in sections 235A.12 to 235A.24, unless the context otherwise requires:

1. "Child abuse information" means any or all of the following data maintained by the registry in a manual or automated data storage system and individually identified:
   a. Report data.
   b. Investigation data.
   c. Disposition data.
2. "Report data" means information pertaining to any occasion involving or reasonably believed to involve child abuse, including:
   a. The name and address of the child and the child's parents or other persons responsible for the child's care.
   b. The age of the child.
   c. The nature and extent of the injury, including evidence of any previous injury.
   d. Any other information believed to be helpful in establishing the cause of the injury and the identity of the person or persons responsible therefor.
3. "Investigation data" means information pertaining to the evaluation of report data, including:
   a. Additional information as to the nature, extent and cause of the injury, and the identity of persons responsible therefor. b. The names and conditions of other children in the home.
   c. The child's home environment and relationships with parents or others responsible for his or her care.
4. "Disposition data" means information pertaining to an opinion or decision as to the occurrence of child abuse, including:
   a. Any intermediate or ultimate opinion or decision reached by investigative personnel.
   b. Any opinion or decision reached in the course of judicial proceedings.
   c. The present status of any case.
5. "Confidentiality" means the witholding of information from any manner of communication, public or private.
6. "Expungement" means the process of destroying child abuse information.
7. "Individually identified" means any report, investigation or disposition data which names the person or persons responsible or believed responsible for the child abuse.
8. "Sealing" means the process of removing child abuse information from authorized access as provided by this chapter. [C75, 77 s235A.13]

Referred to in §§235A.12, 235A.24.

235A.14 Creation and maintenance of a central registry.

1. There is created within the state department of social services a central registry for child abuse information. The department shall organize and staff the registry and adopt rules for its operation.

2. The registry shall collect, maintain and disseminate child abuse informa-tion as provided for by this chapter.
3. The department shall maintain a toll-free telephone line, which shall be available on a twenty-four hour a day, seven-day a week basis and which the department of social services and all other persons may use to report cases of suspected child abuse and that all persons authorized by this chapter may use for obtaining child abuse information.
4. An oral report of suspected child abuse initially made to the central registry shall be immediately transmitted by the department to the appropriate county department of social services or law enforcement agency, or both.
5. The registry, upon receipt of a report of suspected child abuse, shall search the records of the registry, and if the records of the registry reveal any previous report of child abuse involving the same child or any other child in the same family, or if the records reveal any other pertinent information with respect to the same child or any other child in the same family, the appropriate office of the department of social services or law enforcement agency shall be immediately notified of that fact.
6. The central registry shall include but not be limited to report data, investigation data and disposition data. [C75, 77, ss235A.14]

Referred to in §§232.68, 235A.12, 235A.13, 235A.24.

235A.15 Authorized access.

1. Notwithstanding chapter 68A, the confidentiality of all child abuse information shall be maintained, except as specifically provided by subsection 2.
2. Access to child abuse information is authorized only:
   a. To a health practitioner who is examining, attending or treating a child whom the practitioner believes or has reason to believe has been the victim of abuse.
   b. To employees of the department of social services having responsibility for the investigation of a child abuse report.
   c. To a law enforcement officer having responsibility for the temporary emergency removal of a child from the child's parent or other legal guardian.
   d. To a juvenile court or district court upon a finding that information is necessary for the resolution of an issue arising in any phase of a case involving child abuse, except that information obtained through the registry shall not be utilized in any aspect of any criminal prosecution.
   e. To an authorized person or agency having responsibility for the care or supervision of a child named in a report as a victim of abuse or a person named in a report as having abused a child, if the juvenile court or the registry deems access to child abuse information by such person or agency to be necessary.
   f. To a person conducting bona fide research on child abuse, if the details identifying any subject of a child abuse report are deleted.
   g. To a person who is the subject of any report as provided in section 235A.19.
   h. To registry or department personnel where necessary to the performance of their official duties.

i. To a court hearing an appeal for correction or expungement of registry information as provided in section 235A.19.
j. In an individual case, to the mandatory reporter who reported the child abuse. [C75, 77, ss235A.15; 67GA, ch 1090, ss9, 10]

Referred to in §§235A.12, 235A.13, 235A.17, 235A.21, 235A.24.

235A.16 Requests for child abuse information.

1. Requests for child abuse information shall be in writing on forms prescribed by the department, except as otherwise provided by subsection 2. Request forms shall require information sufficient to demonstrate authorized access.
2. Requests for child abuse information may be made orally by telephone where a person making such a request believes that the information is needed immediately and where information sufficient to demonstrate authorized access is provided. In the event that a request is made orally by telephone, a written request form shall nevertheless be filed within seventy-two hours. [C75, 77, s235A.16]

Referred to in §§235A.12, 235A.13, 235A.24.

235A.17 Redissemination of child abuse information. A person, agency or other recipient of child abuse information authorized to receive such information shall not redisseminate such information, except that redissemination shall be permitted when:

1. The redissemination is for official purposes in connection with prescribed duties, or, in the case of a health practitioner, pursuant to professional responsibilities.
2. The person to whom such information would be redisseminated would have independent access to the same information under section 235A.15.
3. A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
4. The written record is forwarded to the registry within thirty days of the redissemination. [C75, 77, s235A.17]

Referred to in §§235A.12, 235A.13, or 235A.21, 235A.24.

235A.18 Sealing and expungement of child abuse information.

1. Child abuse information relating to a particular case of suspected child abuse shall be sealed ten years after the receipt of the initial report of such abuse by the registry unless good cause be shown why the information should remain open to authorized access. If a subsequent report of a suspected case of child abuse involving the child named in the intial report as the victim of abuse or a person named in such report as having abused a child is received by the registry within this ten-year period, the information shall be sealed ten years after receipt of the subsequent

report unless good cause be shown why the information should remain open to authorized access.

2. Child abuse information may be expunged where the probative value of the information is so doubtful as to outweigh its validity. Child abuse information shall be expunged if it is determined to be unfounded as a result of any of the following:
   a. The investigation of a report of suspected child abuse by the department.
   b. A successful appeal as provided in section 235A.19.
   c. A court adjudication.
3. The registry, at least once a year, shall review and determine the current status of child abuse reports which are transmitted or made to the registry after July 1, 1974, which are at least one year old and in connection with which no investigatory report has been filed by the department of social services pursuant to section 232.71. If no such investigatory report has been filed, the registry shall request the department of social services to file a report. In the event a report is not filed within ninety days subsequent to such a request, the report and information relating thereto shall be sealed and remain sealed unless good cause be shown why the information should remain open to authorized access. [C75, 77, s235A.18]

Referred to in §§235A.12, 235A.13, 235A.24.

235A.19 Examination, requests for correction or expungement and appeal.

1. Any person or that person's attorney shall have the right to examine child abuse information in the registry which refers to that person. The registry may prescribe reasonable hours and places of examination.
2. Any person who files with the registry a written statement to the effect that child abuse information referring to such person is in whole or in part erroneous, and requests a correction or expungement of that information, shall be notified with sixty days by the registry, in writing, of its decision or order regarding the correction or elimination. All decisions and orders shall be accompanied by findings of fact, and the registry shall provide the opportunity for a fair hearing when it initially determines that the information should not be corrected or expunged as requested.
3. The registry's decision or order may be appealed to the district court of Polk county by the person requesting the correction or expungement or to the district court of the district in which such person resides. Immediately upon such appeal the court shall order the registry to file with the court a certified copy of the child abuse information. Appeal shall be taken in accordance with the provisions of the Iowa administrative procedure Act.
4. Upon the request of the appellant, the record and evidence in such cases shall be closed to all but the court and its officers, and access thereto shall be prohibited unless otherwise ordered by the court. The clerk shall maintain a separate docket for such actions. No person other than the appellant shall permit a copy of any of the testimony or pleadings or the substance thereof to be made available to any person other than a party to the action or his attorney. Violation of the provisions of this subsection shall be a public offense punishable under section 235A.21.

5. Whenever the registry corrects or eliminates information as requested or as ordered by the court, the registry shall advise all persons who have received the incorrect information of such fact. Upon application to the court and service of notice on the registry, any individual may request and obtain a list of all persons who have received child abuse information referring to him or her.
6. In the course of any proceeding provided for by this section, the identity of for by this section, the identity of the person who reported the disputed information and the identity of any person who has been reported as having abused a child may be withheld upon a determination by the registry that disclosure of their identities would be detrimental to their interests. [C75, 77, ss235A.19]

Referred to in §§235A.12, 235A.13, 235A.15, 235A.18, 235A.24.

235A.20 Civil remedy. Any aggrieved person may institute a civil action for damages under chapter 25A or 613A or to restrain the dissemination of child abuse information in violation of this chapter, and any person, agency or other recipient proven to have disseminated or to have requested and received child abuse information in violation of this chapter shall be liable for actual damages and exemplary damages for each violation and shall be liable for court costs, expenses, and reasonable attorney's fees incurred by the party bringing the action. In no case shall the award for damages be less than one hundred dollars. [C75, 77, ss235A.20]

Referred to in §§235A.12, 235A.13, 235A.24.

2351.21 Criminal penalties.

1. Any person who willfully requests, obtains or seeks to obtain child abuse information under false pretenses, or who willfully communicates or seeks to communicate child abuse information to any agency or person except in accordance with sections 235A.15 and 235A.17, or any person connected with any research authorized pursuant to section 235A.15 who willfully falsifies child abuse information or any records relating thereto, is guilty of a serious misdemeanor. Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child abuse information except in accordance with sections 235A.15 and 235A.17 shall be guilty of a simple misdemeanor.
2. Any reasonable grounds for belief that a person has violated any provision of this chapter shall be grounds for the immediate withdrawal of any authorized access such person might otherwise have to child abuse information. [C75, 77, ss235A.21; 66GA, ch 1245(4), s249]

Referred to in §§235A.12, 235A.13, 235A.19, 235A.24.

235A.22 Education program. The department shall require an educational program for employees of the registry on the proper use and control of child abuse information. [C75, 77, ss235A.22]

Referred to in §§235A.12, 235A.13, 235A.24.

235A.23 Registry reports.

1. The registry may compile statistics and issue reports on child abuse, provided identifying details of the subject of child abuse reports are deleted.
2. The registry shall issue an annual report on its administrative operation, including information as to the number of requests for child abuse data, the proportion of requests attributable to each type of authorized access, the frequency and nature of irregularities, and other per-

Referred to in §§235A.12, 235A.13, 235A.24.

235A.24 Council on child abuse information.

1. There is created a council on child abuse information consisting of nine regular members. Two members shall be appointed from the house of representatives by the speaker of the house, no more than one of whom shall be from the same political party. Two members shall be appointed from the senate by the lieutenant governor, no more than one of whom shall be from the same political party. The remaining members of the council shall consist of a judge of the district court appointed by the chief justice of the supreme court, one local law enforcement official appointed by the governor, the commissioner of the department of social services or his designee, and two private citizens not connected with law enforcement appointed by the governor. The council shall select its own chairman. The members shall serve at the pleasure of those by whom their appointments are made.
2. The council shall meet at least annually and at any other time upon the call of the chairman of the council, or any three of its members. Each nonlegislative council member shall be entitled to reimbursement for actual and necessary expenses incurred in the performance of official duties from funds appropriated to the department of social services. Each legislative member shall receive expenses pursuant to section 2.10 and section 2.12.
3. The council shall have the following responsibilities and duties:
   a. Shall periodically monitor the operation of the child abuse informa-tion registry established by this section and sections 235A.12 to 235A.23.
   b. Shall review the implementation and effectiveness of legislation and administrative rules concerning the registry.
   c. May recommend changes in said legislation and administrative rules to the legislature and the appropriate administrative officials.
   d. May require such reports from state agencies as may be necessary to perform its duties.
   e. May receive and review complaints from the public concerning the operation of the registry. [C75, 77, s235A.24]

Referred to in §§235A.12, 235A.13

PART 2

CHILD ABUSE REPORTING, INVESTIGATION AND REHABILITATION

Transferred from sections 235A.1 to 235A.11.

232.67 Legislative findings-purpose and policy. Children in this state are in urgent need of protection from abuse. It is the purpose and policy of this part 2 of division III to provide the greatest possible protection to victims of potential victims of abuse through encouraging the increased reporting of suspected cases of such abuse, insuring the thorough and prompt investigation of these reports, and providing rehabilitative services, where appropriate and whenever possible to abused children and their families which will stabilize the home environment so that the family can remain intact without further danger to the child. [C66, 71, 73, 75, 77, s235A.1; 67GA, ch 1090, s1]

232.68 Definitions. As used in this chapter, unless the context otherwise requires:

1. "Child" means any person under the age of eighteen years.
2. "Child abuse" or "abuse" means harm or threatened harm occurring through:
    a. Any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the result of the acts or omissions of a person responsible for the care of the child.
    b. The commission of any sexual abuse with or to a child as defined by chapter 709, as a result of the acts or omissions of the person responsible for the care of the child.
    c. The failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child, however this provision shall not preclude a court from ordering that medical service be provided to the child where the child's health requires it.
3. "Department" means the state department of social services and includes the local, county and regional offices of the department.
4. "Health practitioner" includes a licensed physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, optometrist, podiatrist or chiropractor; a resident or intern in any of such professions; and any registered nurse or licensed practical nurse.
5. "Registry" means the central registry for child abuse informa-

tion established in section 235A.14.

6. "Person responsible for the care of a child" means:
   a. A parent, guardian, or foster parent.
   b. A relative or any other person with whom the child resides, without reference to the length of time or continuity of such residence.
   c. An employee or agent of any public or private facility pro-viding care for a child, including an institution, group home, mental health center, residential treatment center, shelter care facility, detention center or child care facility. [C66, 71, 73, 75, 77, s235A.2; 67GA, ch-1090, s2 3]

232.69 Mandatory and permissive reporters.

1. The following classes of persons shall make a report, as provided in section 232.70, of cases of child abuse:
   a. Every health practitioner who examines, attends, or treats a child and who reasonably believes the child has been abused. If, however, the health practitioner examines, attends, or treats the child as a member of the staff of a hospital or similar institution, the examining health practitioner shall immediately notify and give complete information to the person in charge of the institution or the health practitioner's designated agent and the person in charge of the institution or designated agent shall make the report.
   b. Every social worker under the jurisdiction of the department of social services, any social worker employed by a public or private agency or institution, public or private health care facility as defined in section 135C.1, certified psychologist, certificated school employee, employee of a licensed day care facility, member of the staff of a mental health center, or peace officer, who, in the course of employment, examines, attends, counsels or treats a child and reasonably believes a child has suffered abuse. Whenever such person is required to report under this section as a member of the staff of a public or private institution, agency or facility, that person shall immediately notify the person in charge of such institution, agency or facility, or that person's designated agent and the person in charge of the institution, agency, or facility, or the designated agent shall make the report.
2. Any other person who believes that a child has been abused may make a report as provided in section 232.70. [C66, 71, 73, 75, 77, s235A.3; 67GA, ch 1090, sf, 5]

Referred to in §§232.70, 232.75, 232.77.

232.70 Reporting procedure.

1. Each report made by a mandatory reporter, as defined in section 232.69, subsection 1, shall be made both orally and in writing. Each report made by a permissive reporter, as defined in section 232.69, subsection 2, may be oral, written, or both.
2. The oral report shall be made by telephone or otherwise to the department of social services. If the person making the report has reason to believe

that immediate protection for the child is advisable, the person shall also make an oral report to an appropriate law enforcement agency.

3. The written report shall be made to the department of social services within forty-eight hours after such oral report.
4. The department of social services shall:
    a. Immediately, upon receipt of an oral report, make an oral report to the registry;
    b. Forward a copy of the written report to the registry; and
    c. Notify the appropriate county attorney of the receipt of any report.
5. The oral and written reports shall contain the following information, or as much thereof as the person making the report is able to furnish:
    a. The names and home address of the child and his parents or other persons believed to be responsible for his care;
    b. The child's present whereabouts if not the same as the parent's or other persons's home address;
    c. The child's age;
    d. The nature and extent of the child's injuries, including any evidence of previous injuries;
    e. The name, age and condition of other children in the same home;
    f. Any other information which the person making the report believes might be helpful in establishing the cause of the injury to the child, the identity of the person or persons responsible for the injury, or in providing assistance to the child; and
    g. The name and address of the person making the report.
6. The report made by a permissive reporter, as defined in section 232.69, subsection 2, shall be regarded as a report pursuant to this chapter whether or not the report contains all of the information required by this section and may be made to the department of social services, county attorney, or law enforcement agency. If the report is made to any agency other than the department of social services, such agency shall promptly refer the report to the department of social services. [C66, 71, 73, 75, 77, s235A.14]

Referred to in 232.69.

232.71 Duties of the department upon receipt of report.

1. Whenever a report is received, the department of social services shall promptly commence an appropriate investigation. The primary purpose of this investigation shall be the protection of the child named in the report.
2. The investigation shall include:
    a. Identification of the nature, extent and cause of the injuries, if any, to the child named in the report;
    b. The identification of the person or persons responsible therefor;
    c. The name, age and condition of other children in the same home as the child named in the report;
    d. An evaluation of the home environment and relationship of the child named in the report and any other children in the same home as the parents or other persons responsible for their care;
    e. An investigation of all other pertinent matters.
3. The investigation may with the consent of the parent or guardian include a visit to the home of the child named in the report and examination of such

child. If permission to enter the home and to examine the child is refused, the juvenile court or district court upon a showing of probable cause may authorize the person making the investigation to enter the home and examine the child.

4. The county attorney and any law enforcement or social services agency in the state shall cooperate and assist in the investigation upon the request of the department of social services. The county attorney and appropriate law enforcement agencies shall also take any other lawful action which may be necessary or advisable for the protection of the child.
5. The department of social services, upon completion of its investigation, shall make a preliminary report of its investigation as required by subsection 2. A copy of this report shall be transmitted to juvenile court within ninety-six hours after the department of social services initially receives the abuse report unless the juvenile court grants an extension of time for good cause shown. If the preliminary report is not a complete report, a complete report shall be filed within ten working days of the receipt of the abuse report, unless the juvenile court grants an extension of time for good cause shown. The juvenile court shall notify the registry of any action it takes with respect to a suspected case of child abuse.
6. The department of social services shall transmit a copy of the report of its investigation, including actions taken or contemplated, to the registry. The department of social services shall make periodic follow-up reports thereafter in a manner prescribed by the registry so that the registry is kept up-to-date and fully informed concerning the handling of a suspected case of child abuse.
7. The department of social services shall also transmit a copy of the report of its investigation to the county attorney. The county attorney shall notify the registry of any actions or contemplated actions with respect to a suspected case of child abuse so that the registry is kept up-to-date and fully informed concerning the handling of such a case.
8. Based on the investigation conducted pursuant to this section, the department shall offer to the family of any child believed to be the victim of abuse such services as appear appropriate for either the child, the family, or both. If it is explained that the department has no legal authority to compel such family to receive such services.
9. If, upon completion of the investigation, the department of social services determines that the best interests of the child require juvenile court action, the department shall take the appropriate action to initiate such action under this chapter. The attorney shall assist the county department of social services in the preparation of the necessary papers to initiate such action and shall appear and represent the department at all juvenile court proceedings.
10. The department of social services shall assist the juvenile court or district court during all stages of court proceedings involving a suspected child abuse case in accordance with the purposes of this chapter.
11. The department of social services shall provide for or arrange for and monitor rehabilitative services for abused children and their families on a voluntary basis or under a final or intermediate order of the juvenile court.
12. In every case involving child abuse which results in a child protective judicial proceeding, whether or not the proceeding arises under this chapter, a guardian ad litem shall be appointed by the court to represent

the child in such proceedings. Before a guardian ad litem is appointed pursuant to the provisions of this section, the court shall require the person responsible for the care of the child to complete under oath a detailed financial statement. If, on the basis of that financial statement, the court deems that the person responsible for the care of the child is able to bear the cost of the guardian ad litem, the court shall so order. In cases where the person responsible for the care of the child is unable to bear the cost of the guardian ad litem, the expense shall be paid out of the court expense fund. [C66, 71, 73, 75, 77, s235A.5; 67GA, ch 1090, s6,7]

Referred to in §§232.72, 235A.18.

232.73 Jurisdiction-transfer. "Department of social services" or "county attorney" ordinarily refer to the local or county office serving the county in which the child's home is located.

However, if the person making the report pursuant to this chapter does not know where the child's home is located, or if the child's home is not located in the service area where the health practitioner examines, attends, or treats the child, the report may be made to the state department of social services or to the local office serving the county where the person making the report resides or the county where the health practitioner examines, attends, or treats the child. These agencies shall promptly proceed as provided in section 232.71, unless the matter is transferred as provided in this section.

If the child's home is located in a county not served by the office receiving the report, the department shall promptly transfer the matter by transmitting a copy of the report of injury and any other pertinent information to the office and the county attorney serving the other county, they shall promptly proceed as provided in section 232.71. [C66, 71, 73, 75, 77, s235A.6; 67GA, ch 1090, s6,7]

232.73 Immunity from liability. Anyone participating in good faith in the making of a report or photographs or X rays pursuant to this chapter shall have immunity from any liability, civil or criminal, which might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in good faith in any judicial proceeding resulting from such report or relating to the subject matter of such report. [C66, 71, 73, 75, 77, ss235A.7]

232.74 Evidence not privileged or excluded. Sections 622.7, 622.9 and 622.10 and any other statute or rule of evidence which excludes or makes privileged the testimony of a husband or wife against the other or the testimony of a health practitioner as to confidential communications, shall not apply to evidence regarding a child's injuries or the cause thereof in any judicial proceeding, civil or criminal, resulting from a report pursuant to this chapter or relating to the subject matter of such report. [C66, 71, 73, 75, 77, s235A.8]

232.75 Sanctions for failure to report.

1. Any person, official, agency or institution, required by this chapter to report a suspected case of child abuse who knowingly and willfully fails to do so is guilty of a simple misdemeanor.
2. Any person, official, agency or institution, required by section 232.69 to report a suspected case of child abuse who knowingly fails to do so is civilly liable for the damages proximately caused by such failure. [C75, 77, s235A.9; 66GA, ch 1245(4), s248]

232.76 Publicity and educational programs. The department, within the limits of available funds, shall conduct a continuing publicity and educational program for the personnel of the department, persons required to report, and any other appropriate persons to encourage the fullest possible degree of reporting of suspected cases of child abuse. Educational programs shall include but not be limited to the diagnosis and cause of child abuse, the responsibilities, obligations, duties and powers of persons and agencies under this chapter and the procedures of the department and the juvenile court with respect to suspected cases of child abuse and disposition of actual cases. [C75, 77, s235A.10]

232.77 Photographs and X rays. Any person who is required to report a case of child abuse may take or cause to be taken, at public expense, photographs or X rays of the areas of trauma visible on a child. Any health practitioner may, if medically indicated, cause to be performed radiological examination of the child. Any person who takes any photographs of X rays pursuant to this section shall notify the department of social services that such photographs or X rays have been taken, and shall retain such photographs or X rays for a reasonable time thereafter. Whenever such person is required to report under section 232.69, in that person's capacity as a member of the staff of a medical or other private or public institution, agency or facility, that person shall immediately notify the person in charge of such institution, agency, or facility or that person's designated delegate of the need for photographs or X rays. [C75, 77, s235A.11; 67GA, ch 1090, s8]

PART 3

TEMPORARY REMOVAL OF A CHILD

232.78 Temporary removal of a child pursuant to ex parte court order.

1. The juvenile court may enter an ex parte order directing a peace officer to remove a child from his or her home before or after the filing of a petition under this chapter provided:
   a. The parent, guardian, or legal custodian is absent, or though present, was asked and refused to consent to the removal of the child and was

informed of an intent to apply for an order under this section; and

- b. It appears that the child's immediate removal is necessary to avoid imminent danger to the child's life or health; and
- c. There is not enough time to file a petition and hold a hearing under section 232.95.

2. The order shall specify the facility to which the child is to be brought. Except for good cause shown or unless the child is sooner returned to the place where he or she was residing, a petition shall be filed under this chapter within three days of the issuance of the order.
3. The juvenile court may enter an order authorizing a physician or hospital to provide emergency medical or surgical procedures before the filing of a petition under this chapter provided:
   - a. Such procedures are necessary to safeguard the life and health of the child; and
   - b. There is not enough time to file a petition under this chapter and hold a hearing as provided in section 232.95.
4. Any person who may file a petition under this chapter may apply for, or the court on its own motion may issue, an order for temporary removal under this section. An appropriate person designated by the court shall confer with a person seeking the removal order, shall make every reasonable effort to inform the parent or other person legally responsible for the child's care of the application, and shall make such inquiries as will aid the court in disposing of such application. [67GA, ch 1088, s39]

Referred to in §§232.79, 232.95.

232.79 Removal without court order.

1. A peace officer may remove a child from his or her home or a physician treating a child may keep the child in custody without a court order as required under section 232.78 and without the consent of a parent, guardian, or custodian provided that:
   - a. The child is in such circumstance or condition that his or her continued presence in the residence or in the care or custody of the parent, guardian, or custodian presents an imminent danger to the child's life or health; and
   - b. There is not enough time to apply for an order under section 232.78.
2. If a person authorized by this section removes or retains custody of a child, he or she shall:
   - a. Bring the child immediately to a place designated by the rules of the court for this purpose, unless the person is a physician treating the child and the child is or will presently be admitted to a hospital.
   - b. Make every reasonable effort to inform the parent, guardian, or custodian of the whereabouts of the child.
   - c. Promptly inform the court in writing of the emergency removal and the circumstances surrounding the removal.
3. Any person, agency, or institution acting in good faith in the removal or keeping of a child pursuant to this section, and any employer of or person under the direction of such a person, agency, or institution, shall have immunity from any civil or criminal liability that might otherwise be incurred or imposed as the result of such removal or keeping.
4. When the court is informed that there has been an emergency removal or keeping of a child without a court order, the court shall direct the

department of social services or the juvenile probation department to make every reasonable effort to communicate immediately with the child's parent or parents or other person legally responsible for the child's care. The court shall also authorize the department of social services or the juvenile probation department to cause a child thus removed or kept to be returned if it concludes there is not an imminent risk to the child's life and health in so doing. If the child is not returned, the department of social services or the juvenile probation department shall forthwith cause a petition to be filed within three days after the removal.

5. When there has been an emergency removal or keeping of a child without a court order, a physical examination of the child by a licensed medical practitioner shall be performed within twenty-four hours of such removal. [67GA, ch 1088, s40]

Referred to in §232.95.

232.80 Homemaker services. A homemaker-home health aide may be assigned to give care to a child in the child's place of residence. Whenever possible, such services shall be provided in preference to removal of the child from the home. Such care may be provided under this Act on an emergency basis for up to twenty-four hours without court order, and may be ordered by the court for a period of time extending until dismissal or disposition of the case. Expenses incurred under this section shall be paid for according to, and reimbursement from the parent, guardian or custodian may be sought under, the provisions of section 232.14. [67GA, ch 1088, s41]

Referred to in §232,14]

232.81 Complaint.

1. Any person having knowledge of the circumstances may file a complaint with the person or agency designated by the court to perform intake duties alleging that a child is a child in need of assistance.
2. Upon receipt of a complaint, the court may request the department of social services, juvenile probation office, or other authorized agency or individual to conduct a preliminary investigation of the complaint to determine if further action should be taken.
3. A petition alleging the child to be a child in need of assistance may be filed pursuant to section 232.87 provided the allegations of the complaint, if proven, are sufficient to establish the court's jurisdiction and the filing is in the best interests of the child.
4. A person or agency shall not maintain any records with regard to a complaint filed under this division III of this chapter which is dismissed without the filing of a petition. [SS15, s254-a15; C24, 27, 31, 35, 39, s3621; C46, 50, 54, 58, 62, s232.5; C71, 73, 75, 77, s232.3; 67GA, ch 1088, 242]

Referred to in §232.21.

CHAPTER 726

PROTECTION OF THE FAMILY

Referred to in §701.1

Chapter 726, Code 1977, transferred to §725.5 to 725.18.

726.1 Bigamy.
726.2 Incest.
726.3 Abandonment of dependent person.
726.4 Husband or wife may be witness.
726.5 Nonsupport.
726.6 Wanton neglect of a minor.
726.7 Wanton neglect of a resident of a health care facility.

726.1 Bigamy. Any person, having a living husband or wife, who marries another, commits bigamy. Any of the following is a defense to the charge of bigamy:

1. The prior marriage was terminated in accordance with applicable law, or the person reasonably believes on reasonably convincing evidence that the prior marriage was so terminated.
2. The person believes, on reasonably convincing evidence, that the prior spouse is dead.
3. The person has, for three years, had no evidence by which he or she can reasonably believe that the prior spouse is alive.

Any person who marries another who the person knows has another living husband or wife commits bigamy. Bigamy is a serious misdemeanor. [C51, s2706-2708; R60, s4348-4350; C73, s4009-4011; C97, s4933-4935; C24, 27, 31, 35, 39, s12975-12977; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s703.1-703.3; C79, s726.1]

726.2 Incest. A person, except a child as defined in section 702.5, who has sexual intercourse with any person whom he or she knows to be related to him or her, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, commits incest. Incest is a class "D" felony. [R60, s4367-4369; C73, s4030; C97, s4936; C24, 27, 31, 35, 39, s12978; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s704.1; C79, s726.2]

Referred to in §232.68.

726.3 Abandonment of dependent person. A person who is the father, mother, or some other person having custody of a child or of any other person who by reason of mental or physical disability is not able to care for himself or herself, who knowingly or recklessly exposes such person to a hazard or danger against which such person cannot reasonably be expected to protect himself or herself or who deserts or abandons such person, knowing or having reason to believe that the person will be exposed to such hazard or danger, commits a class "C" felony. [C51, s2589; R60, s4212; C73, s3870; C97, s4766; C24, 27, 31, 35, 39, s13236; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s731.7; C79, s726.3]

Referred to in §§2528.7, 726.4.

726.4 Husband or wife may be witness. In all prosecutions under section 726.3, 726.5 or 726.6, the husband or wife shall be a competent witness for the state and may testify to any relevant acts or communications between them, anything in previous statutes to the contrary notwithstanding, provided, however, that no husband or wife shall be called or compelled to testify against the other under section 726.3, 726.5 or 726.6 except upon consent of such witness. [S13, s4775-b; C24, 27, 31, 35, 39, s13231; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s731.2; C79, s726.4]

726.5 Nonsupport. A person, who being able to do so, fails or refuses to provide support for his or her child or ward under the age of eighteen commits nonsupport; provided that no person shall be held to have violated this section who fails to support any child or ward under the age of eighteen who has left the home of the parent or other person having legal custody of him or her without the consent of that parent or person having legal custody of him or her. Support, for the purposes of this section, means any support which has been fixed by court order, or, in the absence of any such order or decree, the minimal requirements of food, clothing, or shelter. Nonsupport is a class "D" felony. [S13, s4775-a; C24, 27, 31, 35, 39, s13230; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, s731.1; C79, s726.5]

726.6 Wanton neglect of a minor. A person who is the parent or adoptive parent or any person having custody of any minor commits wanton neglect of a minor when the person does any of the following:

1. The person knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of such minor.

   A parent or adoptive parent or person having custody who provides his or her minor child exclusively with nonmedical treatment by a religious method of healing permitted under the laws of this state shall not, for this reason alone, be considered in violation of this subsection.
2. The person abandons such minor to fend for himself or herself, knowing that the minor is unable to do so.

Wanton neglect of a minor is a serious misdemeanor. [C50, 54, 58, 62, 66, 71, 73, 75, 77, s731A.1-731A.3; C79, s726.6]

Referred to in §726.4.

726.7 Wanton neglect of a resident of a health care facility. A person commits wanton neglect of a resident of a health care facility when the person knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a resident of a health care facility as defined in section 135C.1. Wanton neglect of a resident of a health care facility is a serious misdemeanor. [C79, s726.7]

APPENDIX B

PREVENTION PROGRAM FOR PERSONAL SAFETY

* * * 4-6 GRADE * * *

Please write "True" or "False" for your answer.

1. If a car is following you, the best thing to do is to go over and tell them to go away. ________
2. Never tell a stranger that you are at home alone. ________
3. Since most adults can be trusted, it is okay to take a ride with an adult you don't know. ________
4. When a stranger offers you a gift, the best thing to do is refuse and walk away, and then tell someone about it. ________
5. We all have the right to say who can touch us and how they can touch us. ________
6. Some touches may be called "good" in one situation and "bad" in another. ________
7. Hitchhiking is safe because you can always jump out of the car if you need to. ________
8. You can tell if someone is dangerous by the way he or she looks. ________
9. If someone touches you in a way that makes you feel confused or uncomfortable, you should keep it a secret. ________
10. If a person's actions bother you, it is best to talk to someone you trust about it. ________
11. I could talk to my parents if I had a "touching" problem. ________
12. I could talk to my teacher if I had a "touching" problem. ________

Write in your age ________ Circle: Girl Boy

School ____________________ Date ____________________

APPENDIX C

Iowa Coalition Against Sexual Abuse
1158 27th Street
Des Moines, Iowa 50311
515-271-2918

Child Sexual Abuse

Resources for Children and Parents

Classroom and Curriculum Materials

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1983

APPENDIX C

Child Sexual Abuse

RESOURCES

The resources on sexual abuse of children are extensive. We have included only information which is directly related to prevention as well as a few resources for recovery.

BOOKS FOR CHILDREN

Red Flag, Green Flag People, Joy Williams
Rape and Abuse Crisis Center, P. O. Box 1655, Fargo, North Dakota 58107
Published 1980, 22 pages, $2.03

A coloring book for three to ten year olds. Presents eight "red flag" situations. Seven involve strangers and one involves a relative: "When a relative touches you in a Red Flag way or a confusing way or makes you do things you don't understand it may be called incest."

Once I Was A Little Bit Frightened, Joy Williams; Illustrated by David Lott
Rape and Abuse Crisis Center, P. O. Box 1655, Fargo, North Dakota 58107
Published 1980, 10 pages, $2.03

A brief story aimed at children in kindergarten through fifth grade. A dark, looming figure is used to illustrate "people (who) want to hurt girls and boys when they're alone." Annie "wonders why some people do things to her" then goes "to a center where they talked to her and her Daddy."

My Very Own Book About Me, Jo Stowell and Mary Dietzel;
drawings by Sally Pierone
Spokane Rape Crisis Network, Lutheran Social Service of Washington, North
1226 Howard, Spokane, Washington 99201
39 pages, $2.00

A workbook for kids, using the concepts of "private parts" and "OK touch" and "not OK touch." Text and sprightly drawings convey a great deal of information. Reinforces children's abilities and rights.

Daddy's Girl, Christi Kissell and Elaine Tibbits
Parents Center, 530 Soquel Avenue, Santa Cruz, California 95062
Copyright 1979, 17 pages

Girls and young women (ages 7-16) explain in their own graphic words what their dad and stepdads did to them. Each of the girls also explains what she learned in therapy and what she would like other girls to know. This might be a useful tool for young women who are victims of incest.

BOOKS FOR CHILDREN (Continued)

"Children's Brochure"
Sexual Assault Center, Harborview Medical Center, 325 Ninth Avenue,
Seattle, Washington 98104
Currently in Xerox form--Expect printing in 1982.

A brochure for 9-11 year olds who have been assaulted to help in sorting out issues and feelings.

You Belong To You
YWCA/Sexual Assault Crisis Center, 310 East Third Street, Flint, Michigan
48502
1980, 26 pages

A coloring book for children using concepts of private parts, different kinds of touching, secrets and telling someone.

BOOKS FOR PARENTS

No More Secrets, Caren Adams and Jennifer Fay
Impact Publishers, San Luis Obispo, California 93406
Published 1981, 90 pages, $3.95

This book is easy to read and practical--not a collection of horror stories. Gives many suggestions of the actual words a parent may use with a child, and the experience of parents who've talked to their kids about sexual assault. Home tested recipes for getting "ooh-icks" out of children.

Includes:
- -Ideas about screening baby sitters.
- -Prevention games to play with children.
- -Clues that may alert a parent that a caretaker is potential-ly dangerous.
- -Suggestions for deciding when a child who has been assaulted needs therapy.
- -Ideas for parents who want to get involved in getting pre-vention information into their school system.

The Silent Children, Linda Tschirhart Sanford
Anchor Press, Doubleday, Garden City, New York
Published 1980, $12.95

Extensive background information on sexual assault of children -- defini-tions, explanations, etc. Half of the book focuses on raising children who are not as vulnerable to assault -- developing self-esteem, self-confidence, learning to say no. Some attention is directed toward children with special needs.

BOOKLETS FOR PARENTS

Childproof for Sexual Abuse, prepared by Early Childhood and Parent Education Specialists, published by the Parent Education Center of Yakima, 4823 Snow-Mountain Road, Yakima, Washington 98908
12 pages

A booklet for parents designed to be used as part of small group parent study sessions. Includes sections of definitions, how and why to talk to your child, normal sexual development and activities for parents to use with children.

"He Told Me Not To Tell", King County Rape Relief, 305 43rd Street, Renton, Washington 98055
Published 1979, 28 pages, $1.50 single copy, $1.00 each/10 or more, $.90 each/100 or more (included in manual)

Children Need Protection, prepared by Carver County Programs for Victims of Sexual Assault, 401 East 4th Street, Chaska, Minnesota 55318

A guide for talking to children about sexual assault. The booklet gives people a better understanding of child sexual abuse, as well as some suggestions to deal with this problem.

Child Sexual Abuse
Resources for Professionals and Adults

FILMS

"Childhood Sexual Abuse: Four Case Studies"

16mm. -color MTI Teleprograms, Inc.
2 reels: 27 min.; 23 min. 4825 North Scott Street
C, PRO, A Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

An overview of the traumatic nature of childhood sexual abuse. Four case histories provide a springboard for discussion of familiar aspects of such experiences, predispositional influences, and the effects in later life. Includes a leader's guide.

"Double Jeopardy"

16mm. -color MTI Teleprograms, Inc.
40 min. 4825 North Scott Street
C, PRO, A Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

Designed to sensitize viewers to the problems of the child-victim during judicial proceedings in sexual abuse cases. The film shows how close cooperation among professional agencies and specialized training of personnel can lessen the trauma for the child.

FILMS (Continued)

"Incest: The Victim Nobody Believes"

16mm. -color MTI Teleprograms, Inc.
23 min. 4825 North Scott Street
C, PRO, A Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

One of the first films to openly address this form of sexual abuse. Candid discussions with three young women convey what it's like to be a child caught in a web of fear, confusion, isolation and guilt. The film is an excellent tool for heightening awareness of the extent of sexual child abuse and its impact on the victim's entire life. Includes a discussion guide.

"Interviewing the Abused Child"

16mm. MTI Teleprograms, Inc.
21 1/2 min. 4825 North Scott Street
C, PRO, A Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

Excerpts from actual and recreated interviews between professionals and abused children serve as the basis for this perceptive training film. Viewers observe various interviewing procedures employed by the pediatrician, a social worker and a teacher. The film reveals methods of establishing rapport, ways to deal with protective feelings toward the abuser, and techniques to make the telling experience therapeutic rather than traumatic for the child. Includes a training manual.

"The Last Taboo"

16mm. -color MTI Teleprograms, Inc.
28 min. 4825 North Scott Street
C, PRO, A Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

The stories of six childhood sexual abuse victims interweave to form this compelling documentary. These poignant vignettes increase viewer's awareness of the trauma involved with such incidents and the need for counseling programs.

"The Sexually Abused Child: Identification and Interview"

16mm. -color MTI Teleprograms, Inc.
10 min. 4825 North Scott Street
PRO Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

An important training aid for school and guidance personnel, the film demonstrates various interviewing techniques when sexual abuse is suspected. A spontaneous unrehearsed interview illustrates the delicate interaction between the vulnerable child and the professional. The film examines methods of establishing rapport, interpreting nonverbal cues, and dealing with the child's protective feelings toward the abuser. Instructor manual included.

FILMS (Continued)

"Shatter the Silence"

Jr. High -High School S-L Film Productions
P. O. Box 41108
Los Angeles, California 90041
(800)323-5343 (312)291-9400

"Child Sexual Abuse: The Untold Secret"

Videotape University of Calgary
Good for junior and senior 2500 University Drive, N.W.
high school Calgary, Alberta, Canada TLN 1N4

"Sometimes It's O.K. to Tattle"

12 minutes -Grades 3-6 MTI Teleprograms, Inc.
Film -$250.00 4825 North Scott Street
Video -$150.00 Schiller Park, Illinois 60176
One Week Rental -$50.00 (800)323-5343 (312)291-9400

This film, consisting of a dialogue between Susan Linn and her puppets, helps children learn about child sexual abuse and people to whom they can turn for help. Teacher's Guide included.

"Some Secrets Should Be Told"

12 minutes -Grades 3-6 MTI Teleprograms, Inc.
Film -$225.00 4825 North Scott Street
Video -$150.00 Schiller Park, Illinois 60176
One Week Rental -$50.00 (800)323-5343 (312)291-9400

Susan Linn and her puppets sensitively help children understand what sexual abuse is and to distinguish sexual abuse from normal love and affection. Teacher's guide included.

"No More Secrets"

16mm. -color O.D.N. Productions, Inc.
16 min. 74 Varick Street, Room 304
E, J.H. New York, New York 10013

This film portrays four young friends at play. As they play, they discuss "problems" they have with adults in their lives. Most of the problems are inappropriate touching that makes them uncomfortable or frightens them. Their friends offer suggestions about ways of stopping the touching or about telling another person who can help them.

"Speak Up! Say No!"

Cartoon filmstrip Krause House
Pre., Kng. P. O. Box 880 Oregon City, Oregon 97045

FILMS (Continued)

"Child Molestation: When to Say No"

16mm. -color/sound Aims Instructional Media
13 1/2 min. 626 Justin Avenue
$220.00 ($25.00/3-day rental) Glendale, California 91201

Depicts children being approached by strangers and suggests responses (e.g., don't take money). Also includes situations involving a neighbor and a relative. Kids seem to like it. Needs discussion to balance approach. Intended for 4th-8th graders, but is too young for 7th and 8th graders.

"Who Do You Tell"

16mm. or 3/4" videocassette MTI Teleprograms, Inc.
11 min. -color/sound 4825 North Scott Street
$195.00 ($25.00/one week rental) Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

Includes both animation and footage of discussions among children. Depicts a broad range of problem situations, e.g., if you're lost, if your house catches fire. Relatively short amount of time on sexual assault. Good discussion starter. Aimed at children 6-11.

"The Touching Problem"

16mm. -$350.00 MTI Teleprograms, Inc.
3/4" Video -$315.00 4825 North Scott Street
One Week Rental -$60.00 Schiller Park, Illinois 60176
(800)323-5343 (312)291-9400

This film was originally produced as a half-hour television special by KVOS-TV in association with the Coalition for Child Advocacy, Bellingham, Washington. The film increases viewers' awareness of the emotional trauma experienced by the victimized child, while presenting specific techniques for teaching sexual abuse prevention skills to young children.

"Better Safe Than Sorry"

16mm. -color Filmfair Communications
14 1/2 min. 10900 Ventura Blvd.
E, J.H. P. O. Box 1728
Studio City, California 91604
(213)985-0244

This film speaks directly and frankly to children between nine and fourteen about dangerous situations. The film stresses the use of good judgement as different situations are presented and viewers are challenged to come up with workable ways to handle each problem.

CURRICULUM DEVELOPMENT

Sexual Abuse Prevention: A Lesson Plan, Sandra L. Kleven
1981, 5 pages

The Coalition for Child Advocacy, P. O. Box 159, Bellingham, Washington 98227

A mini-sexual abuse prevention lesson plan for teachers who are familiar with the problem of sexual abuse and want guidelines to assist in classroom discussion.

Uses the film, "Who Do You Tell" as the basis for discussion.

Sexual Abuse Prevention--"A Unit in Safety", Renton School District No. 403
Adopted June, 1981, 21 pages

A comprehensive unit for second-graders, included in the safety component of the health education curriculum. Includes six activities, designed to be used over a one to two week period: "Differences in Touch," "Who Is An Offender," "Learning to Say No," "Who to Tell, How to Tell," "Remembering the Description" and "Review Activity."

Child Sexual Abuse Prevention Project: An Educational Program for Children, Cordelia Kent, Published 1979, 120 pages, $8.00

Hennepin County Attorney's Office, Child Sexual Abuse Prevention Project, C-2000 Government Center, Minneapolis, Minnesota 55487

A guidebook for developing curriculum materials. This is the work that has formed the basis for much of the current prevention work.

Committee for Children--Judicial Advocates
Ruth Harms, P. O. Box 19464, Seattle, Washington 98109, (206) 543-4847

Curriculum and teacher training packet (in process) for elementary school children.

CURRICULUM FOR DEVELOPING AN AWARENESS OF SEXUAL EXPLOITATION AND TEACHING SELF-PROTECTION TECHNIQUES

Developmental Disabilities Project
Contact: Ellen Ryerson, Seattle Rape Relief, 1825 South Jackson, Suite #102, Seattle, Washington 98144

A comprehensive curriculum for the developmentally disabled. Uses audio tapes, pictures, supplemental stories and slide shows.

MORE GOOD IDEAS

The Touching Problem, Sandra L. Kleven and Joan Krebill
1981, 32 pages, $5.50 (includes postage)

The Coalition for Child Advocacy, P. O. Box 159, Bellingham, WA 98227

Reviews the development and activities of the S.O.A.P. (Serious Overatures About People) Box Players, a drama group of the Coalition for Child Advocacy in Bellingham. Included are the scripts from four skits which are aimed at preventing sexual abuse.

"Seasons" depicts a youngster's response as she is victimized over the years.

"Jimmy's Bedtime Story" dramatizes a mother talking to her 7-year- old about sexual assault.

"The Classroom" demonstrates a presentation to second graders.

"Helping Susan" depicts two reactions--a destructive one and a positive one--of a mom to the news that her daughter has been assaulted.
A videotape "The Touching Problem" is also available for $80.00. The videotape includes parts of the dramatized skits as well as other information.

Sometimes I Need To Say No!, Play and Music by Lisa W. Strick
Approximate playing time: 35 minutes, $3.00

Assault Awareness and Avoidance for Children - Grades 1-5

Rape Crisis Center of Syracuse, 423 W. Onandaga St., Syracuse, NY 13202

A series of short skits using songs and humor. The approach is based on a privacy continuum and moves from the general to specific issues of sexual assault. Includes "Some Things Are My Own," "Sometimes I Need To Say NO" and "Sometimes I Like To Be Touched (and sometimes I don't)." Includes supplemental activities for teachers, parents and kids.

Study Cards

Illusion Theater, 528 Hennipin Avenue, #309, Minneapolis, MN 55403

Thirteen cards 14" x 22" with images of the Touch Continuum on one side and discussion tools to complement other sexual abuse prevention.

Parent/Child Self-Protection - Alternatives to Fear

Py Bateman, 101 Nickerson, Suite #250A, Seattle, WA 98109, (206) 282-0177

Classes which address the needs of both parents and children in responding to attempted sexual assault of the child. Instructors work separately with parents and with children as well as with groups of parents and children together.

DISENHOUSE --- SEXUAL ABUSE

BOOK LIST

The Broken Taboo: Sex in the Family
Blair and Rita Justice
Human Sciences Press
72 Fifth Avenue
New York, New York 10011 291 pages

The purpose of this book is to bring into the open the subject of incest that has been hidden and neglected, but affects more families than has been imagined. The book covers the topics of the characteristics of the incestuous family, why incest occurs, the causes and the roles played by participants and nonparticipants. Also, included are the consequences of incest to the family and possible treatment responses. Lastly, the book covers what can be done on the public level as prevention.

Handbook of Clinical Intervention in Child Sexual Abuse
Suzanne M. Sgroi, M.D.
Lexington Books
D.C. Health and Company
Lexington, Massachusetts 384 pages

Dr. Sgroi provides practical guidelines for every facet of treating both child and family and of providing the support services needed to prevent further abuse. This book explains the complex psychological defenses that the concerned professional must anticipate in dealing with child sexual abuse, and it discusses the values and techniques of different modes of therapy. It presents step-by-step procedure for reporting, investigating, and validating the offense; interviewing the child; and preparing for court. It also analyzes the problems of case management, agency coordination, and program evaluation.

Sexual Abuse of Children: Selected Readings
National Center on Child Abuse and Neglect Children's Bureau
Copies can be purchased from: LSDS
Department 76
Washington, D.C. 20401
(DHHS Publication #(OHDS) 78-30161)

This book presents selected readings concerning the dynamics and effective prevention and treatment of child sexual abuse. It also contains a collection of writings by adult and teenage victims of child sexual abuse. The appendices contain several hospital protocols for the physical examination and diagnosis of child sexual abuse cases. It also contains a list of child abuse and neglect treatment programs.

Betrayal of Innocence - Incest and Its Devastation
Susan Forward and Craig Buck; 1978 J.P. Tarcher, Inc.
Los Angeles, California 186 pages

Co-authored by a psychotherapist who specializes in incest treatment, the book covers dynamics of incestual families and analyzes 25 case histories. Also discussed are treatment methods used by one of the authors who was a victim of incest.

Book List (Continued)

Conspiracy of Silence
Sandra Butler; 1978
New Glide Publishers
San Francisco, California 208 pages

Discusses the dynamics of incest and society's response, or lack of. Excerpts from interviews with various members of incestual families are included.

Frances Ann Speaks Out - My Father Raped Me
Helen Chetin; 1977
New Seed Press
Stanford, California 20 pages

A conversation between grandmother and granddaughter regarding her experiences in an incestual family. The print is large and the words are simple. Good for children in similar situations.

I Know Why The Caged Bird Sings
Maya Angelou; 1977
Random House, Inc.
New York, New York 246 pages

An autobiography of a black woman which includes a rape of the author when she was eight years old.

Incest
Karin C. Meiselman; 1978
Jossey-Bass Publishers
San Francisco, California 366 pages

Provides a cause and effect look at incest, showing how incest can result in adjustment problems in adolescents and adults. The author is a clinical psychologist who treats incest victims.

Kiss Daddy Goodnight
Louise Armstrong; 1978
Hawthorn Books, Inc.
New York, New York 256 pages

The author placed an ad: "I am a woman writer doing the first person documentary book on incest. I would like to hear from others who had an actual or near actual incest experience." This book is mostly comprised of answers to this ad. An excellent book. Fairly sexually explicit.

Book List (Continued)

Protecting the Child Victim of Sex Crimes Committed by Adults
Vincent DeFrancis, J. D.; 1969 The American Humane Assn. (Children's
Division) P. O. Box 1266
Denver, Colorado 80201 230 pages

A research project, spanning a three year period, initiated to study the effectiveness of child protective service programs when extended to help child victims of sexual crimes. Sample cases were drawn from New York Boroughs. Strongly encourages the utilization of preventive services at the first sign of family breakdown.

Sexual Assault of Children and Adolescents
Ann Wolbert Burgess, A. Nicholas Groth, Linda Lytle Holmstrom and Suzanne
M. Sgroi; 1978
Lexington Books Lexington, Massachusetts 245 pages

Designed to help professionals who deal with child victims, this book presents an inclusive scope of the problem of child sexual abuse victims.

Silent Sin, The: A Case History of Incest
John Woodbury and Elry Schwartz; 1971
New American Library
New York, New York 224 pages

A clinical psychologist documents the pathology resulting from a young woman's incestuous relationship with her father. Therapy sessions are described in detail and the steps toward mental health are noted.

Vulnerable Children
Lindy Burton; 1968
Schocken Books
New York, New York 277 pages

This book is a study of three groups of children; children involved in road accidents, sexually assaulted children, and children suffering from asthma, which attempts to find underlying causitive factors in the behavior of problem children.

Sleep Disorders

Bruno A. Bielat

Abstract: The assessment, diagnosis, and treatment of sleep disorders are conceptualized from medical and psychological perspectives. Information is offered to expand awareness regarding sleep disorders as both symptomatic and a disorder entity in itself. Role considerations, basic assessment techniques, interventions, and practical information are presented.

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Introduction

All humans sleep. In fact sleep may be one of the most essential needs of human beings. Scientists of many disciplines regard sleep as a fundamental process involved in mood, behavior, exercise of intelligence, and health and illness in both the mental and psychological status of being.

Although school psychologists fill a diverse set of roles in their work, treating sleep disorders is not regarded as a primary role function. This statement is not meant to suggest that school psychologists do not recognize the importance of their client's sleep. However, since the approximate one-third of life spent in sleep is done during times not associated with school, the focus on sleep often becomes incidental rather than customary, unless of course sleeping occurs during school time.

Although the explorations of sleep is relatively new in its current dimensions, one research trend suggest that sleep disorders are characteristic of many mental illnesses. With this in mind, the ability to recognize the symptoms and conditions underlying disturbed sleep patterns and the ability to treat the cause of these symptoms and conditions in addition to their effect provides a valuable tool for school psychologists in their preventative and reactive treatment of children's disorders. In addition, the awareness of treating the effect of sleep disorders also is important, since the response to treatment gives insight into the needs of clients. It is with this rationale in mind that this chapter is offered.

Background

Only within the last 50 years has it become clear that sleep is an active rather than a dormant process, and only within the past 30 years have the fundamental sleep concepts that are used today been established. It was in 1937 that Loomis, Harvey, and Hobart discovered the different stages of sleep by monitoring the amplitude and frequency of electrical activity through EEG measurement during sleep. It was the discovery in 1953 by the landmark study of Anserinsky and Kleitman that bursts of rapid eye movements occurred during sleep. It was their determination that these REM periods were associated with such physiological activities as increased heartbeat and respiration and that the REM period correlated with the ability to recall dreams. Today, this study is viewed as the major impetus for growth in the field of sleep research.

In addition, in 1962, a number of investigators simultaneously concluded that REM sleep is one type of sleep while NREM sleep is another type of sleep altogether. The implication of this work also continues to have impact on research being conducted today. Currently, research efforts are directed as determining the physiological and psychological mechanisms associated with each state.

Sleep Disorders: A listing

With Reschly's (1982) caution about the inflated nature of prevalence estimates in mind, sleep disorders of varying types of degrees of severity purportedly affect as many as 1/3 of all Americans, with insomnia being the most frequent complaint. However, other forms of sleep disorders, although not as prevalent, are worth noting either as primary disorders themselves or as secondary to other disorders. A listing of these disorders is offered by Usdin and Hawkins (1980) and Reynolds, et al. (1981) under the general categories of (1) too little sleep (2) too much sleep (3) disorders associated with sleep (4) sleep disorders secondary to other pathological conditions. Although all four areas will be surveyed, specific focus will be given only to the first three.

The Insomnias: By definition insomnia is the real or imagined inability to get to sleep or stay asleep. The following are considered various forms of insomnia:

1. Pseudoinsomnia - Complaint of insomnia from a client who sleeps six or more hours.

2. Insomnia related to psychological disorders - includes such disorders as schizophrenia, and/or acute or chronic anxiety.

3. Organic/Neurological Insomnia - Central Sleep Apnea which is characterized by the cessation of diaphragm movement during sleep in which breathing stops, and the client awakens.

4. Nocturnal Nyoclonus - this insomnia is frequently accompanied by the restless legs syndrome in which spasmodic leg jerks awakens the client.

5. Insomnias related to circadian disturbance - these include jet lag phase lag, (night person) and phase lead (fall asleep early - rise early) syndromes.

6. Drug Dependent Insomnias - these include the use of stimulants such as caffeine, the paradoxical affect of sedating drugs such as alcohol, and the dependency or tolerance of certain drugs.

The Hypersomnias: By definition, hypersomnia refers to dysfunctional sleep in the form of excessive daytime sleepiness without nocturnal sleep deprivation. The following are considered hypersomnias:

1. Narcolepsy - A condition marked by an uncontrolled desire for sleep or sudden attacks of sleep at inappropriate times. It is considered a REM sleep dysfunction.

2. Kleine-Levin syndrome - Excessive daytime sleepiness without REM sleep dysfunction and without the refreshed and alert feelings after sleep.

Parasomnias. By definition parasomnias are activities which are not in response to external stimuli that occur during sleep. The following are considered parasomnias:

1. Night terrors (pavor nocturnus) - Characterized by sudden awakening with, excessive reactions of fear and discomfort. This occurs without recall of dream content. It usually occurs after 90 minutes of sleep.
2. Sleep Walking (somnambulism) - Ambulatory movement during sleep in which client has full possession of basic sensory information but no subsequent recollection of the experience.
3. Head Banging (Jactatis Capitis Nocturna) - Rhythmic movement with accompanying head banging during sleep.
4. Dream Anxiety Attacks - Sudden awakening with accompanying fear reaction and ability to recall dream content.
5. Bruxism - Grinding or gnashing movements of the teeth while sleeping.
6. Nocturnal Enuresis - Clients who continue to wet themselves at night after the age of three and/or who after achieving bladder control relapse into persistent bedwetting.

Sleep Associated Disorders. By definition these disorders alter sleep because of a variety of medical conditions. These conditions include but are not limited to brain tumors, infections, acute pain, and hypo-thyrodism.

Assessment and Diagnostic Procedures

Normal Sleep

In order to assess disordered sleep patterns, normal sleep must be understood. Generally speaking sleep is divided into two states: REM and NREM. According to Usdin and Hawkins (1980) the other names for NREM and REM states are "S" for synchronized and "D" for desynchronized, "othodox" and paradoxical" sleep, and "quiet" and "activated" sleep. The various stages within these two sleep states were determined by Loomis in 1937 through the use of electroencephatograms (EEGs) which showed five distinct stages.

These stages with a brief description are defined by Ruch and Zimbardo (1971):

Stage 1 - This stage represents about 5% of sleep. Respiration and heart rate begin to reduce. Body muscles begin to relax. This lasts only a few minutes. If awakened at stage 1 the individual may disclaim sleep.

Stage 2 - This stage represents about 50% of sleep. EEG data reflects quick bursts known as spindles and K-complexes which are thought to be responses to internal and external stimuli. Eyes appear to roll slowly.

Stage 3 - This stage in combination with stage 4 represents approximately 20% of sleep. Muscles are very relaxed. Heart and respiration rate is slow. Body temperature and blood pressure declines. Normal sensory events have no impact on disturbing sleep.

Stage 4 - This stage represents the deepest sleep with regular body functions being at their lowest point. Sensory perception is intact, however, brain systems that convert stimulation to conscious sensation do not work in the usual way. Sleep in this stage occurs during the first half of night.

State 1 REM-This stage represents about 25& of sleep. It is similar to stage 1 sleep, but it is accompanied by rapid eye movements and no motor activity. The EEG pattern resembles that of an alert person in a working state, however the person is deeply asleep. In this stage dreaming occurs.

During the sleep process there is a drifting from one state to another with stages not occurring with equal frequency. Throughout the sleep period, the sleeper alternates between non-REM and REM states. The non disordered sleeper reaches deepest sleep (Stage 4) about an hour and a half after going to sleep. Thereafter, the depth of sleep becomes increasingly lighter. For that reason it is easy to understand why two hours of sleep are far better than none at all. It is also easy to understand why some people can function well on as little as four hours of sleep.

The first episode of REM sleep occurs after the completion of stage 4 sleep. Thereafter, REM sleep recurs at 90 minute intervals throughout sleep. Following the initial episode of REM and non REM sleep, stage 2 sleep is the transitional stage between REM and non REM sleep. The transition from one stage to another lasts for approximately seven to eight hours.

Assessment.

The school psychologist's understanding of normal sleep and how it contrasts to disordered sleep promotes the role as initiator of the assessment and diagnostic process for school-aged children. Since sleep disorders are as complex and idiosyncratic as the personality of each child, accurate assessment centers around careful and purposeful interviewing.

Morrison (1983) cautions about the use of published questionnaires, since they tend to reflect the research emphasis of their authors. With this caution in mind the school psychologist can review a variety of comprehension questionnaires such as those developed by Wanzie and Zeplin (1973), Ander's (1980) Sleep Habits Questionnaire and the Stanford Sleep Inventory and develop a personal set of questions that reflect their knowledge about normal versus abnormal sleep. These questions which could be directed to children, depending on their age, and/or to their parents might include the following listings:

Questions for older children/adolescents.

1. How long does it take you to fall asleep at night?
2. How often do you wake up during the night?
3. How long do you sleep at night?
4. What time do you usually go to sleep at night?
5. What time do you usually wake up in the morning?
6. What do you do before you go to sleep?
7. How many nights per week do you have trouble sleeping?
8. Do you eat or drink before you sleep?
9. Do you have good dreams at night? Do bad dreams wake you?
10. Do you take naps on weekends?
11. Do you change your sleeping habits on weekends?
12. Do you feel that you don't get enough sleep?
13. Do you feel that you get too much sleep?
14. Are you bothered by sleeping spells during the week?
15. Are you tired during the day?
16. Do you take naps? When? How often?
17. Are you taking any medicines?
18. Do you take anything to help you sleep?

19. Has there been anything unusual that has happened to you while you are sleeping?

Questions for parents. Does your child:

1. walk during sleep?
2. talk during sleep?
3. awaken during sleep?
4. have restless nights?
5. make grinding sounds during sleep?
6. breathe irregularly during sleep?
7. snore?
8. have nightmares?
9. wet the bed?
10. display rocking movements during sleep?
11. resort to sleeping when they are angry, alone, or sad?
12. display fearful reactions during sleep activity?
13. express fear about going to sleep?
14. fall asleep suddenly during daytime hours?
15. complain about being tired?
16. sleep too much?

An affirmative response to any of the above questions would prompt further questioning. The most obvious of these questions would include estimates of frequency, duration and intensity. The survey's answers coupled with basic background information, which might include a description of bedroom facilities as well as bedtime routine, can provide valuable information in the assessment process. Caution must be exercised when utilizing data from self or parent reports since judgment regarding the nature of the quality of sleep or the nature of the sleep patterns is subjective. Negative responses as well as affirmative ones may be biased by what the child or parent considers normal. Furthermore, some questions may not be answerable, since the parent or child has not had the opportunity to observe the behaviors. With this in mind questions should be presented in either a survey format with follow-up discussion, or if presented in interview format, with open-ended questions first then proceeding to more specific questions when the nature of the problem emerges. (Usdin and Hawkins, 1981).

Diagnosis

Diagnosis may or may not be considered appropriate for the school psychologist. The most pressing issue in determining the level of school psychologist input is the extent to which disordered sleep affects the clients' school functioning. The level of involvement also will depend on the psychologist's treatment expertise as well as the nature and severity of the disordered condition. Affirmative responses to parent questionnaire numbers 6, 7, 9, 12, and 14 in this chapter may require medical evaluation to proceed any psychological treatment. In fact, medical evaluation may be a necessary assessment procedure in almost all cases where sleep may be considered disordered because of the potential physiological foundations. From a medical perspective successful accurate diagnosis is the initial step in successful treatment. Also from a psychological perspective this may not necessarily be the case. A review of various treatment techniques will support this position.

For the school psychologist diagnosis requires more than applying client data to match definitions of disorders. In a case where sleep behavior affects school work in the absence of a medically significant condition, information regarding the nature, frequency, and severity of the condition will determine who makes the diagnosis. A school psychologist, receiving a disordered sleep referral, who makes an attempt to determine the level of intervention to remedy the problem is offering a diagnostic statement. Initiating intervention whether it be consulting, direct intervention, or determining whether treatment is required from other sources to a degree also must be considered as at least a partial diagnosis.

It is widely felt that an accurate diagnosis leads to effective treatment. From a medical perspective this is typically the case. However, from a psychological perspective accurate diagnosis may be validated by the conclusion of the treatment process. In this perspective, determining the level and type of treatment may lead to accurate diagnosis after the effects of treatment have been evaluated.

Intervention

Ford (1982) asserts that diagnosis and intervention not only depend on each other, but they demand one another. In the case of sleep disorders a variety of interventions such as medication, behavior modification, cognitive behavior modification, common sense, thought control training, and information giving are utilized. The school psychologist's participation in either medication monitoring, direct or indirect psychotherapeutic procedures, or consultation about environmental manipulation depends directly upon their level of expertise in these matters. In this area the foundation elements of expertise are based in awareness of treatment alternatives. Although the assumption may be made that diagnosis and intervention demand one another, the psychologist's level of expertise dictates the level of treatment to be attempted. For the purpose of this chapter, treatment will be considered from two major perspectives: psychologically based and medically based. Although an overlapping between two areas frequently exists in treatment, this distinction is made to assist psychologists in determining treatment boundaries between the medical and psychological professions. Information regarding treatments beyond the role of psychology provides awareness of treatment alternatives.

Insomnia

Medically based treatment of insomnia commonly includes a prescription for sleeping pills. However, many times insomnia is a symptom rather than a disorder entity in itself. Therefore, a prescription for sleeping pills does not take into account the many possible difficulties of which insomnia may be indicative. A review of the variety of psychological treatments for insomnia lends credence to this position.

For example, Carrera and Elenewski (1980) investigated the effects of imagery-based therapy without relaxation with the hypothesis that inplosive therapy would be an effective procedure, if it were targeted specifically toward the fear of death. Treatment consisted of visualizing being at home in bed and having difficulty falling asleep. Subjects then were instructed to attend to body functions and then to fantasize about having a disease. Subjects were guided through progressive physical and emotional deterioration and finally were instructed to visualize their own death.

Specifically, targeted therapy treatment in this study was compared to a more generalized form of inplosive therapy. The results of the study suggested that the targeted treatment was superior to the generalized form. The authors used their findings to support the psychoanalytic interpretation and insomnia being the fear of death, and that a reduction of death fear and anxiety can reduce the latency of sleep onset.

In a more positive approach Levine (1980) reports that the treatment of childhood insomnia through the use of personalized fairy tales. In her presentation of two case studies involving their effective use, she describes a hypnotic method without formal trance which allows children to feel a controlling influence in putting a favorite, make-believe figure to sleep.

The procedure for treatment includes designing a fantasy which is audiotaped for replay prior to the child going to sleep. The fairy tale includes the child's favorite objects, the interaction of the child with fantasy creatures, the fantasy figures dealing with the stresses of the child, the fantasy figure falling asleep in the child's lap, and finally the child falling asleep so the fantasy figure is not disturbed. The advantages of this approach appear to be in the applicability of treatment to very young children done in the comfort of their home.

From a Eriksonian developmental theory perspective, Wagner (1983) reports that the quality of an individual's sleep depends on the individual's adequacy to resolve the relevant psychosocial conflicts. In her studies investigating the "identity-versus-role-confusion" psychosocial crisis and insomnia, she indicates that students who report sleep disturbances show significantly less effective resolution of the psychosocial crisis specific to their stage of development. Although generalizing the findings to specific practice were qualified, implications of treating the behavioral correlates of development were offered as a means of preventative and reactive treatment.

Insomnia as an indicator of the effects of significant life events also merits consideration. Healey's, et al. (1981) study of insomnia indicates that stressful life events, when mediated by predisposing factors such as personal vulnerability, are related to the onset of chronic insomnia. He speculates that internalized psychological conflicts mitigated by stressful life events lead to emotional arousal and to physiological activation during sleep. Furthermore, he proposes that poor sleepers internalize their reactions to life events rather than externalizing their responses through overt behavior. He concludes from this retrospective study that stressful life events should be viewed as a contributing factor relating to the onset of insomnia.

From this rationale Healey suggests that an early goal in the treatment of insomnia is to assist the insomniac in regarding the disorder as related to their waking lives. This would include the muscle tension-release did not have an impact on the use of cognitive attending treatments.

Of interests to therapists is the imagery treatment itself. Imagery treatments used in this study included training and home practice of thought control to preclude focusing on somatic sensations. Common objects (candle, kite, light bulb) were used as prompts and were faded. Subjects were taught to become proficient at imagining specific features, color, and movement of the object and were told to practice the techniques at home to improve their sleep patterns. This treatment was presented at a self control technique with self reporting being utilized as the basis for result documentation.

In another study Shealey (1979) reported the effectiveness of various treatment techniques on the different degrees and durations of sleep onset insomnia. In addition to such treatments as progressive relaxation training, stimulus control, passive relaxation, a placebo effect (discussion about sleep), a waiting list control group, and self-monitoring treatment also were used. It is important to note that the self monitoring treatment consisted of filling out a daily sleep questionnaire that probed daily activities and the quality of sleep.

Shealy found both relaxation and stimulus control were effective treatments of sleep onset insomnia. He indicated that progressive relaxation may be more efficient to passive relaxation in the dimension of time used to relax. The study did not support the isolated use of self monitoring as a technique for decreasing sleep onset latency. However, the author indicated that self monitoring used in conjunction with the total treatment process merits consideration.

In another comparative study of relaxation to other variables the authors found another factor to be prominent. Nicassio, et al. (1982) conducted a study comparing progressive relaxation, EMG biofeedback and a biofeedback placebo in the treatment of sleep onset insomnia. The results of the study indicated that neither the progressive relaxation nor the EMG feedback were significantly more effective than the placebo biofeedback treatment. Given these results, elaboration on the feedback and placebo feedback treatments warrants attention.

EMG biofeedback has shown promise in the treatment of insomnia (Coursey, et al., 1980, and Weiss, 1973). Insomniacs are provided feedback through a modular system which informs them about the level of tension in their forehead. During sessions users are instructed to relax by focusing on physical and mental sensations which reduce the feedback signal. Although it provides the insomniac with information, placebo feedback treatment is inaccurate, non-contingent feedback from the device that is regulated by therapist manipulation. The critical feature of this treatment is the therapist suggestion that tension had been reduced significantly.

Nicassio's results strongly suggest that a therapist effect, in this case expecting the ability to relax, may contribute to enhance. Instead, both progressive relaxation and stimulus control were shown to be effective.

An additional study warrants attention since it takes into account psychological and behavior principles. That study was conducted by Weitzman, et al., (1981) who describes a treatment for insomniacs whose complaint is limited to an inability to fall asleep at socially accepted time. These people fall asleep and continue to sleep at a time indepedent of social, family and occupation demands. He describes this syndrome as delayed sleep phase insomnia and refers to its treatment as "chronotherapy".

Treatment consists of advancing the sleep-wake time schedule 3 hours per day through a carefully supervised setting. If, for example, the client usually falls asleep around 3 A.M. then Day 1 of treatment would permit the client to go to sleep at 6 A.M. and to wake at 10 A.M. Day 2 of treatment would permit the client to begin sleep at 9 A.M. and to wake at 1 P.M. This resetting procedure continues through Day 7 when the client is permitted to go to sleep at 12 midnight and must awaken at 7 A.M. The authors contend that once the circadian phase shift is accomplished, the sleep onset insomnia disappears. The long range effect of this treatment has not been determined.

In addition to drug therapy treatment, psychologically based approaches are used to treat the same disorders. For example, Framer and Sanders (1980) in a reported case study treatment utilized contingency contracting to eliminate an adolescent sleep disorder consisting of sleep talking, walking and nightmares. Behaviors accompanying the disordered sleep were family communicative in nature. The authors treated the disordered sleep by attempting to reduce the environmental stress linked to a negative parent-child relationship. Treatment consisted of contingency contracting sessions in the form of "if-then" contracts, which were negotiated by parents and child. Compliance was exchanged for increased privileges.

Framer and Sanders found that the level of sleep disturbances correlated positively with child behavioral and communication improvement and family communication. The authors concluded that behavioral treatment, in this case family contingency contracting, is a positive alternative treatment strategy with a greater potential of patient compliance when compared to other treatments typically used.

In another example of treatment without medication, a behavioral treatment of night terrors has been offered by Kellerman (1979) for use with very young children. In generalized form the treatment consists of the following four steps.

Step 1. Parents are informed about sources of anxiety. Information about progressive muscle relaxation also is provided to reduce anxiety accompanying stressful events.

Step 2. Child is desensitized to sources of anxiety through systematic desensitization.

Step 3. Positive reinforcement system is used when restful night sleep in experienced.

Step 4. When a night terror is experienced only minimal reassuring statements are provided such as "Mommy's here." Prolonged periods of attention after a night episode were discouraged.

It is important to note that this treatment approach combined anxiety reduction and respondent conditioning techniques in the management of this disorder without the use of medication. It also is important to note that parental anxiety was reduced through providing support via a treatment plan. This may serve to counteract the potential rewarding aspects of this disorder and other sleep disorders, which may be enhanced and perpetuated by parental attention.

In contrast to the previously reported drug therapy approach to sleep walking, Clement (1970) offers a behavioral approach that eliminated somnambulism in a 7-year old boy. After determining that the sleep walking episodes were preceded by such physiological responses to nightmares as sweating and sleep talking, treatment consisted of complete awakening during nightmares and returning to bed to act aggressively towards self-drawn pictures depicting the recurring theme of the nightmares. The author reported a significant reduction in sleepwalking behavior within six weeks of behavioral treatment and extinction of the behavior in a 6 month follow-up study.

Nightmares also have been treated through psychologically-based methods. For example, Kellerman (1980) used an incompatible response treatment paradigm based on reciprocal inhibition to reduce anxiety associated with nightmares in children. In the case presented, it was determined that the nightmares represented an anxiety reaction to a terror film. The child in the study was instructed that he could not be afraid and angry at the same time to the frightening figure in the film, and that being angry at the figure would help. Therefore, treatment consisted of drawing the figure and displaying anger by destroying the picture. In addition the child's parents were instructed not to reinforce fearful behaviors at night. If fear was expressed they were instructed to say "you can handle it." Furthermore, appropriate sleep behavior was reinforced monetarily.

It is important for psychologists to note that this behavioral treatment calls for the specification of stimuli associated with nighttime anxiety. The practice of inhibiting behaviors in a behavioral climate where appropriate sleep behaviors are reinforced, according to Kellerman, assists in developing a behavioral treatment plan that can be generalized to a variety of nighttime anxious behaviors.

Hypersomnias

Traditionally the hypersomnias have been treated by the medical profession. For example, stimulants and antidepresants are used to treat the principal symptoms of narcolepsy. In addition, counseling and education for both the patient and family are needed treatment elements. These elements include:

1. Designing a regular regimen of sleep to avoid sleep loss.
2. Assisting in the day scheduling of short naps for approximately 15 minutes to offset sleep attacks.
3. Providing information about the consequences of high risk activities such as child care and operating machinery.
4. Offering emotional support.
5. Monitoring medication and its associated features such as tolerance and withdrawal. (Usdin and Hawkins (1980).

Sleep apneas also are treated principally by the medical profession. Symptomatic excessive daytime sleepiness and the loud snoring are treated by reducing or eliminating respiratory obstruction. In children this typically takes the form of surgically removing tonsils and/or adenoids. For adult sufferers, tracheotomy with a daytime closure valve is considered the treatment of choice. (Usdin and Hawkins (1980).

Personal survey of the literature does not indicate psychotherapeutic techniques for narcolepsy or sleep apnea. The Kleine-Levine syndrome with its lack of specific etiology may warrant psychological assessment and treatment, since the nonspecific attacks of daytime sleepiness resemble psychological/social withdrawal.

Monitoring

Monitoring is an integral part of treatment. In the case of disordered sleep, daily or nightly report inventories consisting of those questions presented previously in this chapter would be utilized either by parent or child on a pre- and post therapy basis. Self-monitoring, although criticized in the area of validity, merits some consideration in its effect as a treatment technique in itself for older children.

Jason's (1975) finding that self-monitoring is effective in reducing sleep onset insomnia, although not substantiated by replication efforts, signals the importance of self-monitoring as a part of the total treatment approach for any sleep disorder. The failure to reproduce this study by Shealy (1979) suggests that self-monitoring as a part of treatment or as a treatment in itself will depend upon the nature and severity of the disorder. No doubt the duration of the disorder prior to treatment also will have impact on deciding the type of monitoring to be used.

Discussion

The school psychologist's awareness of diagnostic elements and of the available interventions for treatment of sleep disorders assists in defining role performance, and in general improves client care. Although there are many possible services school psychologists could provide to sleep disordered children, all seem to fall under one of the following categories:

1. Screening for possible medical disorder
2. Initiating referral to another source of assistance
3. Facilitating social and medical adjustments
4. Assisting family members to achieve their understanding
5. Supporting therapeutic compliance with other professionals
6. Providing direct or indirect therapeutic assistance

However, before fulfilling any of the above-mentioned roles, the wise school psychologist will exercise caution. Consider some qualifications that make the "art" of diagnosis and treatment a challenge.

For example, for children, parasomnias and to a degree insomnia are problems frequently experienced in early and middle childhood. In most cases medical or sleep specialist intervention is not indicated unless problems persist into adolescence. Such disorders as sleep walking, talking, and night terrors usually dissipate with neurological development. Although these disorders rarely indicate severe physiological or neurological disorders, medication may be utilized depending on the perceived severity of the case. In the case of night terrors, for example, although neurological growth is usually sufficient for eliminating the problem, a sedating medication such as valium is used by medical personnel for more immediate effects. Given the side effects of this medication and the child's lack of awareness regarding the behaviors associated with the disorder, in a distorted sense it is probably to the child's advantage for the medication to be prescribed to his parents. However, it is possible that reassurance based on knowledge from the school psychologist could provide a similar effect.

To a degree, child insomnia could be handled in a similar fashion. For example, a school psychologist's knowledge about stimulus control interventions for insomnia also can provide a mild intervention alternative. Successful intervention can reduce anxiety which in turn can prevent a "snow-balling" effect for the disorder itself and can reduce the anxiety and stress related to its symptoms. Again, a lessened need for medication.

School psychologists also need to remember that although the prevalence of parasomnias diminishes towards the onset of adolescence, hypersomnias and disorders associated with the sleep-wake cycle become more prevalent during adolescence. In the case of adolescent sleep apnea, surgical procedures are an effective means to free the upper respiratory area from blockage. Obviously, diagnosis and treatment for this disorder fall within the medical realm. The diagnosis and treatment for excessive sleepiness is by far more complex.

There are few school psychologists who have never received a referral on an adolescent whose characteristics include "always seems to be tired, seems lazy, lacks motivation, and doesn't seem to care." For these same clients, suspicion about substance abuse or an excessively demanding social life usually precludes any thoughts about the possibility of narcolepsy or the Klein-Levine syndrome. Although there is recognition that significant physiological changes occur at the onset of adolescence which manifest themselves in sleepiness, an assumption too often is made that sleepiness is under the control of the client. The fact remains that sleepy individuals who are affected by narcolepsy may learn to feel lazy and unmotivated because they do not have the control of their sleepiness. These behaviors are in response to resentment, disgust, and anxiety related to the lack of personal control. In this case the implications for school psychological practice in regard to role participation demand caution.

Furthermore, from a slightly different perspective school psychologists also would do well to remember that disordered sleep has a close relationship with depression and anxiety. When these conditions do exist with a sleep disorder, each problem should be addressed separately. For example, anxious or depressed insomniacs feel that their problems would disappear with improved sleeping. Since their sleep cannot be improved by trying harder, the depressed or anxious feelings are enhanced as obsessive thoughts about sleep and trying to fall asleep prevail. In some cases the precipitating stressor no longer has impact on the individual, however, the insomnia persists, since the sleep loss itself becomes the catalyst for the psychological symptoms. In addition, never assume that there is covariance in improvement. The separation of disorders into difference problems requires the evaluation of the different components for successful treatment.

Finally, hopefully the reading of this chapter did not put the reader to sleep even though it may be a relaxing and comforting activity in the evening. If you are reading this late at night and you can't seem to fall asleep you might consider the following recommendations to improve your sleep hygiene or the sleep hygiene of others:

1. Regular exercise promotes good sleep. Aerobic exercise in the later afternoon or early evening can help induce sleep. However, aerobic exercise immediately prior to sleep is stimulating and inhibits sleep.
2. Eating and/or watching television in bed can disrupt a sleep routine.
3. Appropriate environmental conditions promote good sleeping. The bedroom temperature should be between 55 and 65 degrees. A reduction of intruding noise and light are preferable. The condition of sleep clothing, mattress, and pillow should receive attention. Checking the humidity level also is important.
4. A warm shower or bath prior to sleeping promotes sleeping since the warmth relaxes muscles. A relaxed body sleeps better.
5. A regular bed time routine prior to going to sleep, which includes regular bedtime and wake time, promotes good sleep.
6. Caffeinated beverages, chocolate, spicy foods, and alcohol inhibit and disrupt sleep.
7. Foods such as milk, cheese, turkey, and beef contain an amino acid called L-tryptophan that promotes sleep. L-tryptophas can be purchased in capsule form at many nutritional food stores.
8. Try to avoid using sleeping medications. Sleep obtained from their use is not as restorative as naturally induced sleep.

Appendix

For additional information about sleep disorders or for a listing of sleep disorders regional clinics write to:

Association Sleep Disorder Center
Box 204
Del Mar, CA 92014

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Decision Making Quandries for Children and Adolescents

Deb Hill

Abstract: A framework for analyzing decision making processes is presented. Case illustrations highlight the decision making quandries for children and adolescents. Implications for school psychologists are offered.

Chapter Outline

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Introduction

To be or not be be, that is the question."
Hamlet, Shakespeare

"Adam, do you think we should eat this apple?"
Eve, the Creation Story

"Diana, will you marry me?"
Prince Charles, 1981

"Geraldine, will you be my running mate?"
Mondale, 1984

Decisions, decisions, decisions! As the above questions suggest, people have been struggling with decision making quandries since the beginning of recorded history. We have all been caught between our desires and obligations and have no doubt experienced decision making quandries. Trying to sort out our feelings and weigh them against the more abstract notion of "the right or best thing to do" is a continual challenge and puzzle. While we often think of decision making in terms of large and significant events such as marriage, career, college, graduate school, we also make a myriad of choices each day in our routine, mundane interactions with others. It is this aspect of decision making, the routine and mundane, that affords a rich, fertile field for the school psychologists working with children, parents and teachers. Helping clients become aware of the many choices they make each day and the influence of those choices on others, as well as how to exert better control over those choices is an effective key to behavior change.

Definition, Background and History

Decision making at first glance appears to be a somewhat over-explored area of human behavior. A brief review of the literature suggests that traditional step by step approaches to teaching decision making skills are adequate models and sufficient to assure quality decision making. In the daily practice of school psychology, it does not take too long to conclude that faulty decision making is the crux of many behavior problems we encounter on a regular basis. It is also quickly apparent that the problem is more subtle than the more traditional concepts about decision making suggest. The issue here is the gap between the expressed intent of a parent, teacher, student and their actual behavior. We have all had the experience of working out a behavioral contract with parents, teacher and student regarding homework completion, for example, and discovering a week later that none of the parties to the agreement have followed through on it, with the possible exception of the school psychologist! The need is to understand the decision making behavior of parents, children, and teachers as a means of understanding what happens when typical behavior interventions don't work. The actual behavior of the parent/child/teacher indicates their real choice, although they may not be aware of it. How to help them become aware of their choices and then change their behavior by making a better choice is the goal of this paper.

The scope of this paper is to focus primarily on the behavior of children, specifically the analysis of decision making problems and possible interventions. In reality, children do not make decisions in isolation, but most frequently in response to stimuli created by parents and teachers. While the emphasis is on changing child behavior and improving the child's decision making skills, it is recognized that parents and teachers are key variables and their behavior must be considered as well as the child's. The target population includes for example, the youngster who is capable of completing academic tasks successfully but who consistently fails to do so; the youngster who does the work but doesn't hand it in; and the youngster who works well with the teacher but who can't work independently. This is the youngster who is referred because of poor academic achievement and the teacher wonders if "she is really capable of doing the work." Test results indicate that these youngsters have grade level skills and are capable of average academic achievement. While the same principles may apply, essentially the focus here is on the non-handicapped youngster who is experiencing difficulty due to poor decision making skills. Our task is to determine what decisions the child is making relative to task completion, academic achievement, peer interaction, etc., and how to effectively intervene to change that decision making behavior.

It is important at the outset of our exploration to recognize several basic premises about decision making. It is first of all a developmental process, a premise strongly supported by the literature. Much of the research is devoted to career decision making in adolescence, and while career decision making will not be specifically addressed, some of the basic principles apply to our discussion. Clearly the decisions of adolescence are markedly different from those made by elementary aged children. Havinghurst (1972) "developed a psychosocial theory of adolescence that recognizes both individual's needs and societal demands. This merger of needs and demands constitutes the core idea of a developmental task." (Scavaneveldt and Adams, 1983) The various developmental steps in the maturation of decision skills have been researched and discussed at length, particularly in regard to adolescents and will not be reviewed here. Suffice it to say that this author is persuaded to accept the developmental nature of decision making skills and that is reflected in the case illustrations presented later in our discussion.

One further point needs to be made with respect to discussion of the decision making process in the literature. The chief dilemma has involved perceiving decision making as an exclusively rational or emotional process, i.e., one or the other, but not both. This frame of reference has been applied to major decisions such as choice of career, college or spouse. Indeed, much of the focus has been on teaching rational decision making skills relative to the most significant decisions a person makes in his/her lifetime. While teaching rational decision making strategies is helpful, in some instances it is not enough. Most decisions have both rational and emotional elements to them and relying exclusively on one or the other modality often results in confusion and less than satisfactory outcomes. Deciding whether or not to have an abortion for example is a highly emotional decision. Deciding on a package of financial investments is a more rational decision. However, there are rational and emotional aspects to each of these decisions. The most helpful model is that which integrates the rational and emotional components of decision making.

The decision making model which has been most useful to me within the everyday practice of school psychology has been the "Choice Awareness Model" of Richard Nelson (1980). This will be outlined in greater detail at a later point. However, it is important to note his definition of choice as "any action, response, or feeling over which the individual does, or can learn to exercise some control." (Nelson 1976, p. 463) This definition of decision making gets us immediately into the daily business of learning to manage interactions with others which is the crux of most behavioral difficulties. The bottom line is that there are a huge number of "choice points" or decision points which we encounter each day. Our task is to become aware of these choice points and to learn how to make the most of them. More significantly, our task is to become aware of these choice points in the interactions of children with their parents, teachers and peers, and use that awareness to help children exercise better control over their choices.

Before continuing with the Choice Awareness Model, let's look briefly at some of the common components of major decision making models which occur most frequently in the literature. The behavioral approaches (Russell and Roberts, 1979, Krumboltz 1967) generally rely on the principles of modeling, successive approximation and behavioral rehearsal. Seven steps outlined by Russell and Roberts were used to teach decision making skills to elementary aged students. A decision making chart was used as the primary teaching tool and the children were given problem scenarios. The seven steps are:

1. Identify the problem.
2. Generate alternate solutions.
3. Think of positive and negative consequences for each solution.
4. Collect information relevant to the problem.
5. Compare alternatives with personal values.
6. Make the decision.
7. Re-evaluate the decision at a later time.

Using this model, the data of Russell and Roberts supports the hypothesis that 7 year olds can improve their decision making skills and the quality of their decisions.

The models for adolescents, while somewhat more complex, break into two major categories, process models and style models. The Process Model (Maskay and Juhasz, 1983) is described primarily in regard to sexual decisions, although potential application is much broader. When considering adolescent decision making, according to Maskay and Juhasz, three underlying elements need to be assessed, specifically; cognitive competency and developmental needs (Piaget, Maslow); locus of control (Rotter); and the historical perspective (Erickson) which includes the adolescent's ability to think about the past and hypothesize about the future. In assessing an adolescent's decision making skills, according to Maskay and Juhasz, one needs to determine the youngster's ability to assess.

1. The event(s) which made the decision necessary.
2. The available alternative choices of action.
3. Overall positive outcomes when weighed against negative consequences.
4. The most desirable, workable, and practical choice of action.

Then one can teach the adolescent to use the following seven steps for decision making:

1. Identifying the decision to be made.
2. Determine why it is needed.
3. Identify the alternative choices for action.
4. Analyze the information and hypothesize about positive and negative consequences.
5. Evaluate desirability of various choices.
6. Estimate the practicality of behaviors.
7. Decide on a conclusion for action.

Overall, the behavioral and process models are quite similar and reflect a goal of teaching step by step rational approaches to decision making skills to both children and adolescents.

The Style Models (Harren, 1976) as applied to adolescents describe three different types:

*Planning Style:	The decision maker seeks a wide variety of data and evaluates it. This is a rational fact finding approach.
*Intuitive Style:	The decision maker emphasizes feelings, emotion and fantasy. The emphasis is on what "feels right," not data.
*Dependent Style:	The decision maker uses the thoughts, opinions and recommendations of others and takes little responsibility for independent data collection. The situation dictates the variables used or considered.

These three styles are used according to the different types of decisions to be made (Harren and Kass, 1977). Problems arise when different styles or models are not available to the decision maker, i.e., a rational research oriented approach used for the choice of a college might work well, but not so well for the choice of a spouse. The Style Models do identify the emotional components of decision making as well as the cognitive/rational aspects. Integration of emotional and cognitive aspects of decision making is not widely researched in the literature on decision making. However, it is this author's belief that consideration and evaluation of both emotional and rationale components is a key variable in understanding and effectively managing the decision making process.

Assessment

I have found the most helpful system for working with children in managing/teaching decision making skills is the CREST Program developed by Richard C. Nelson in 1980. This program focuses both on teaching children how to deal affectively with their choices of exploring how feelings control actions and on teaching them to deal behaviorally with their choices in order to expand their behavioral response repertoire. This system has advantages over previously mentioned systems because it integrates the affective/emotional and cognitive/behavioral aspects of decision making. There are 15 basic concepts to this system. They are based on the definition of choice mentioned earlier, specifically choice is "any action, response or feeling over which the individual does, or can learn to exercise some control." (Nelson, 1976) The basic concepts are as follows:

1. "Children make many choices daily." Children exhibit a variety of behaviors each day over which they have some degree of control. Whether to interact with another student, try something new, complete a project or hand in a worksheet are examples of choices children encounter each day. (Making choices is a high frequency occurrence).

2. "In each choice, children have many options." Children can respond with a yes to a request from a parent, teacher or peer, but even a simple yes can have great complexity. The yes can be a grudging yes, enthusiastic or non-committal. It can be a yes that really means no. While the behavior appears quite simple, there can be a host of emotional complexity which accompanies it. Children need to become aware of their decision habits and learn to recognize possible alternatives so that they can exercise choice in a variety of ways.

3. "Children have an instant in which to choose." When confronted with a stimulus, a child has a split second in which he/she makes an internal choice or decision. If hit during a game, a youngster has the opportunity to assess the situation and then retaliate or not. Most children make a large portion of their choices on the basis of habit, and do not use that split second

to consider alternative responses. Often, children do not appreciate that there are other responses than whose which they habitually rely on. Their habits vary according to the different people in their environment. The key is that habits can be changed, but to do so children need to become aware of the internal choice they make before they respond.

4. "Relationship affect children's choices." Children make the same choices with different people and receive a wide variety of responses. They also discover that the response of the same person may vary from time to time. If the response is consistently negative, the children will narrow their range of choices thereby limiting responses in their behavioral repertoire. The patterns can become habituated and stereotyped according to age, sex, etc., and the child becomes increasingly limited to available behavioral choices.

5. "Goals affect children's relationships." The primary goal for children is to obtain warmth and caring from significant others in their environment. Children need help to understand that they have goals with other people, both short and long term goals. Often they do not see how a short term goal, "I want to get back at Mom, so I'll give her the silent treatment" can seriously interfere with a long term goal of " I want to be able to talk with Mom and for her to understand me." Becoming aware of both short and long range goals can help children make better choices in reaching them.

6. "Children's choices may be OK or OD." This concept provides a way for children to evaluate their choices by considering them as OK or OD. Some examples of OK choices are saying hello, returning a pencil, picking up dirty clothes. These are relatively minor OK choices. Major OK choices are giving a hug, doing a favor for someone, giving a sincere compliment. By contrast, OD choices are those that are overdone, overdosed or over-drawn if you think of a bank account. The metaphor is that children have an "Interpersonal account with others who are important in their lives." (Nelson, 1980) OK choices are credits to that account and OD choices are debits to the account. Minor OD choices are actions that irritate others, a thoughtless comment, not listening, being late. Major OD actions include yelling, fighting, hitting, running away. As with OK choices, the OD choices fall on a continuum and any behavior can be placed somewhere on this continuum. When evaluating their choices, children can decide to make more OK choices or fewer OD choices.

7. "Children have five kinds of choices." This is a more qualitative type of evaluation system to help children understand the types of choices they are making. The acronym CREST describes the five types of choices; Caring, Ruling, Enjoying, Sorrowing, Thinking/working. The same behavior can fall into more than one category depending on the situation, and there is

overlap. Deciding which category a response fits into is not the most important point. The real issue is that children can be helped to understand what types of choices they are making and whether those choices are OK or OD. Relationship problems can be understood in manageable terms and behavioral change is understood in terms of making better choices in future interactions with others. The categories help children recognize the emotional/affective component of the choices they make each day.

8. "Children making Caring choices." These include reassuring, assisting, reflecting feelings, guiding, defending, etc. These are typically caring choices, however, the OD side of caring is smothering. Our choices are reflected in our verbal and non-verbal behavior towards self and others. They may be new or habitual behaviors. Children need to learn to initiate caring behavior as well as recognize the caring behavior of others. Statements such as "Are you OK?"; "Do you feel well?" are examples of caring behavior.

9. "Children make Ruling choices." These choices include the assertion of leadership and can include offering, suggesting, scolding, forbidding, setting limits. The OD side of ruling is to be bossy and domineering which usually creates problems in relationships. Children are often not aware of the ruling choices they make, especially with peers and siblings, e.g., "I'm not going to; I'll tell mom; Cut it out; Give that to me!" Children are often not aware of the frequency of their ruling choices nor of the effects of those choices on other people in their lives.

10. "Children make Enjoying choices." This includes having fun, being playful and creative, loving and being loved. The OD side of enjoying for children can include teasing, having fun at someone else's expense, avoidance of work and responsibility. Frequently children learn from adults to connect enjoying choices to large and specific events such as a visit to the zoo, the circus, a fishing trip or party. They need to identify the many enjoying choices that can be made in daily interactions with others. To smile rather than frown, to help rather than whine and complain, and to think positively about themselves are all enjoying choices which can be made on a daily basis.

11. "Children make sorrowing choices." This includes being sad, worrying, crying, pouting, feeling hurt, stealing, lying, and feeling sorry for myself. The OD side of sorrowing is meanness or miserableness and this interferes significantly with relationships to others. Children need to learn that sad things happen and that there are OK ways to handle these things. Habitual or stereotyped behavior can interfere in these choices, i.e., boys learn to fight back and girls learn to cry rather than defend themselves. Other ways of dealing with sorrowing choices include talking to others, expressing feelings, and working through what bothers them.

12. "Children make Thinking/Working choices." These include such things as asking questions, planning and doing a project, intellectualizing and procrastinating, making excuses. These choices occur with high frequency in school. Flunking a class because of doing no work, task avoidance, and over-achieving teacher pleasing behaviors are all examples OD thinking/working choices. These choices are most often in children's relationships with adults because parents and teachers supervise and monitor the work which children do. Children can be given more responsibility for their thinking/working choices and can learn to make OK choices in the thinking working area.

13. "Children influence consequences." Children can learn to positively influence the behavior of others. They can also learn how they are influenced by others, such as peers and teachers they especially like. With awareness of this two-way influence, children can make more deliberate choices as to how they will behave in order to have the desired influence. Children can learn to be initiators of actions with peers, teachers and parents. They do not have to wait passively until the other person's behavior changes. They can take an active role rather than always react to what others do or say to them. This can include decisions to be friendly with others, to tell someone when they are angry, hurt or upset with them and so forth.

14. "Children choose their feelings in the moment." Children experience a variety of feelings in response to a set of stimuli. They can learn to identify what they are feeling, i.e., concern, frustration, anger and on which of those feelings to act. For example, if they receive a poor grade on a test, their response is likely to include anger, fear (of what parents will say), confusion (as to how it happened), and frustration (over what to do about it). They can choose to act on only one of those feelings, anger, and wad the paper up and pitch it. They can also learn additional responses such as asking for help, better test preparation, etc. which will more effectively solve the problem.

15. "Children can choose how they feel about themselves and others." Children learn about themselves from the reactions of other people. They learn to label themselves as shy, dumb, sissy, bright, jock, popular, loner and so on. They can learn to discard these labels and recognize that they have a wide variety of ways to define themselves and they can act on those options. They learn that when they make OK choices other people usually follow with OK responses. They can be helped to make small, relatively easy OK choices and to then build on that success.

The chief objective of this approach is to teach children to be initiators of behavior by helping them become aware of the variety of choices available to them in each interaction with others. Children can learn to examine their behavior and from that, determine what choice they actually made in any given interaction situation. Richard Nelson has written several books, In the Land of Choice, The Magic of Choice, A Wondrous Change, for teaching choice awareness to children. There are user manuals and supplementary materials which accompany these books. This package comprises a total curriculum which can be implemented in a traditional classroom setting for the whole class. It is also possible to use the principles in choice awareness theory to understand the behavior of clients and to design more effective interventions. The best way to demonstrate this is through case illustration.

Before looking at specific cases, it would be helpful to review some preliminary cautions regarding assessment and diagnosis. In order to determine that the referred student truly has a decision making problem, it is important to rule out other problems. Most typically, a student is referred due to poor academic achievement and there are often accompanying behavior problems. Data need to be collected to determine whether the student has the capacity to do the work or not. Academic achievement test scores, individual assessment of cognitive and academic skills and observational data can provide the school psychologist with clues in each individual case. Essentially, if you discover that the child is capable of doing grade level work and test data supports that conclusion, then you are most likely dealing with a "motivational" or more accurately a decision making problem.

Handicapped youngsters also experience decision making problems and essentially, the choice awareness theory can be applied to behavioral interventions with them. However, I have found it most useful in working with students who are referred but generally not eligible or not currently in special education programs. The types of decision making problems which I have encountered in children include perfectionism, habitual resistance and procrastination. These will be examined more closely in case illustrations. The common element to all three cases is that none of the youngsters saw themselves as responsible for their own behavioral choices. The interventions were designed to make them aware of the choices they were making and to plan new choices for the future. The three cases involve a variety of ages and situations and include:

Bonnie...The Junior High Know-It-All
Terri...The Perfectionist
Nathan...The Boy With No Choices

Bonnie...The Junior High Know-It-All

Bonnie is a 7th grade girl and this is her first year in a junior high setting. She is hearing impaired but is able to function with hearing aids which she wears in both ears. Bonnie had received special education services in elementary school, but had gradually worked herself out of the resource program in 6th grade. She really wanted to be out of the program and did not want to be in special education in junior high. Test data at the time she was staffed out indicated that Bonnie had the necessary skills to be successfully mainstreamed.

Once in junior high, Bonnie initially attracted administrative attention because of her frequent trips to the office and the nurse. Once out of class, Bonnie would roam the halls, rarely ever reaching the office or the nurse. A conference was held with Bonnie and her mother and it was explained that she would no longer be excused from class for any reason since she could not conform to school rules when she was out of class. After this was implemented by the vice-principal and the nurse, Bonnie began making OD choices in the thinking/working areas and in the sorrowing, feeling sorry for myself areas. She took romantic novels to class and read them rather than doing the assignments. She began getting in fights with peers who picked on her during passing time. By the first reporting period Bonnie was failing most courses except for reading and home ec and was racking up a fairly sizable disciplinary record. Another conference was held and this time a referral was made to the school psychologist with the recommendation that Bonnie return to special education on a full time basis.

A third conference was held with Bonnie, her mother, her counselor, and this psychologist. Bonnie made it very clear that she did not wish to return to special education during our initial interview. We pointed out that her behavior would have to change in order to make us believe she meant what she said, because her present behavior indicated that she was making very poor choices. We obtained teacher reports from each of her classes and shared these with her during the interview. We then noted with special emphasis the two classes in which she was able to behave and earn good grades. Bonnie replied that the reason was because she liked the teachers and was interested in the subjects. She added that her other classes were boring and that she "knew it all, already, so why study?" She also said that she didn't like the teachers and they didn't like her.

This provided an opening to closely examine the choices Bonnie was making and the consequences of those choices. We made it clear to her that she had decided that if you don't like the teacher or the subject, you don't have to study or do the work. We pointed out that her choice was hurting her, not the teachers. She was the one facing the return to special ed, not the teachers. We also were able at that point to work with Bonnie's mother to help her become aware that she was OD on the caring choices with Bonnie. Mother had been letting Bonnie come home if she called up in the middle of the day complaining she felt sick. Having helped Bonnie and her mother each become aware of the choices they were making, we then proceeded to write a behavioral contract.

Bonnie's mother had promised her a color TV if she brought up her grades. This promise alone had not been effective in changing Bonnie's behavior. Using the TV as the ultimate reward, we restructured the program to include several contingencies. Bonnie was to receive weekly reports from each teacher on her grades and her behavior. She was to take these reports home every Friday to her mother. She was to earn passing grades in all subjects (a minimum of "D") and improve her behavior. This was operationalized as no more novels in class and work completed. We again pointed out that because of her good reports from two classes, we knew that she could make OK choices about her thinking/working behavior.

We also set up weekly meetings with Bonnie and myself to monitor the program and further examine the choices she was making. This was written up as a contract which all the parties then signed. We included a follow-up conference date of three weeks to review progress.

During our weekly meetings, Bonnie brought the teacher reports and we charted the improvement of her grades and behavior. Specifically, we discussed how she was making better choices with respect to thinking/working behavior in class. A problem remained with respect to peer relationships in that although the fights decreased, Bonnie continued to experience negative, hostile interactions on a daily basis. During our interviews, she had portrayed herself as the victim of peer abuse, much as she had claimed to be the victim of teacher unfairness. She claimed innocence as far as instigating any of the negative interactions with peers. This issue was more complicated to address because unlike academics where she knew how to be a good student in at least two classes, Bonnie's experiences with peers had been pretty consistently negative.

One day, I happened to be in the hall and observed Bonnie deliberately knock another student's books on the floor and then threaten to hit him. When she noticed me, she immediately drew her hand back and turned away. When we met later that day, I mentioned the incident I had earlier witnessed. Bonnie began with a chorus of what the other student had done to deserve her reaction. What I then did was take out a piece of paper and folded it in half lengthwise. On one side of the fold she listed each student and what they had done to her. On the other side she had to write how she had chosen to react. It looked something like this:

Jane called me a bitch	and I tripped her
Joe said I was ugly	and I knocked his books on the floor.

She continued until she had recalled all the events of that particular day. We then folded the paper so that we could only see the "and I..." statements. We read through these together and Bonnie began to realize that she had been OD on the sorrowing or hurtful, negative choices. While acknowledging that others could be unkind and hurtful, Bonnie became aware of her behavior and realized that it was contributing to her problems with peers. In subsequent sessions she worked on writing other choices she might make in response to peers. She experimented with ignoring them, making a joke of it, avoiding especially bothersome students with teacher help, and so on. While Bonnie did not reach the point of initiating caring choices with peers, the peer abuse decreased and her disciplinary referrals to the office markedly decreased. By the end of the semester, her grades had improved to B and C in most areas and she was at least passing in all subjects. The referral to special ed was dropped and Bonnie earned her TV. She had learned to decrease her OD choices during the semester and had experienced positive consequences of her choices.

Terri...The Perfectionist

Terri is a 6 year old first grader who was referred because of poor achievement. The work she did was generally correct and well done, however, her rate of production was quite low. She worked well when the teacher worked individually with her. The chief problem was lack of generalization of skills from working with the teacher to an independent work setting. The teacher was quite confused because she did not know whether Terri lacked the ability, was learning disabled or just lazy. The teacher wanted to know how much to expect from Terri and whether to push her to improve her performance.

During the course of an individual evaluation, this psychologist noted that Terri was quite anxious about her performance and frequently asked how well she was doing. She would begin a task and then stop, seemingly afraid she had done something wrong. She carefully watched my face for clues as to whether I approved or disapproved of what she had done. The testing situation did not permit corrective feedback other than in the most general terms. Over the course of a two hour period, Terri became more and more withdrawn and less willing to engage in the task at hand.

When formal testing was completed, I gave Terri a piece of paper and asked her to scribble as much as she could. Her demeanor changed dramatically. She suddenly sat up straight and put a lot of energy into her scribbling. When the pencil wore down, she ran across the room to sharpen it and then ran back to her seat. She scribbled furiously on both sides of 9 sheets of paper and wore down a new pencil to the eraser. The most noteworthy observation is that she was given permission to make a mess and given the choice, she acted on it. This indicated to me that Terri had serious anxiety about making mistakes, and in school work, she was choosing to do nothing rather than risk making a mistake. This basic choice to OD on task avoidance rather than risk making errors was seriously interfering with her ability to make progress in learning.

A visit with Terri's mother confirmed my hunch. It turned out that Terri was an only child and that her mother was an interior decorator. Consequently, Terri was not allowed to make any messes at home and had to work really hard to keep things just so. Since she had no idea how to put things back exactly how they were, she learned to do nothing and not risk being reprimanded for making a mess. This behavior choice of doing nothing rather than risk messing up had generalized to all situations so that when Terri came to school, she preferred to do nothing rather than risk messing up. She would only do those worksheet or tasks which she knew she could do perfectly and avoided everything else.

We designed a behavioral intervention to teach Terri how to make mistakes. We explained to her mother how the environment at home left Terri with very limited behavioral choices. While her mother could appreciate this cognitively, she had a really hard time accepting alternative choices which included messy behavior. She was agreeable to any behavior program that was school based, so we decided to focus our efforts on school related issues and dropped a home intervention program.

In the school program we decided to focus primarily on math at the outset. Through an individual interview with Terri, I explained how it seemed that she had a hard time coping with math. I pointed out that math was very frustrating because there was only one right answer and a person could so easily make mistakes. She agreed that this was a problem for her. I proposed that we try an experiment in math which went as follows: For the next week Terri was to do all her math papers incorrectly. If she put the correct answers, that would be marked as wrong. She thought this was very funny and seemed excited about it. After a week, she and I and her teacher would review how the experiment went. The other stipulation was that she had to do all her math papers. We also visited with her teacher who agreed to the experiment and to help keep track of her progress on a chart. We explained that if she could do every problem wrong, then we'd know the experiment was working. Also, if she was doing the problems incorrectly, then we'd know that she could also figure out how to do them correctly. Above all, she was not to worry about making mistakes because that's what the experiment was all about, teaching her to make mistakes.

After a week, Terri had greatly improved her output of work in math. She was earning smiley faces for perfectly incorrect papers. During the second week, she made the comment to her teacher that if she knew how to do the problems correctly, why did she have to keep on doing them wrong. The teacher agreed that her question was an OK question and that we ought to all discuss it. Later that week a conference was held with Terri, her teacher and this psychologist. Terri posed her question to me and we were able to discuss how she now had a choice of whether to do her math problems correctly or incorrectly. She agreed that it was OK to make this choice and she would now prefer to do them correctly rather than incorrectly. We helped her to realize that it was OK to make mistakes and that she learned that bad things don't happen if math problems are incorrect. Her teacher reinforced this by saying that it was better for Terri to choose to do her math papers and make some mistakes rather than do nothing at all. We set up a monitoring system to keep track of Terri's work completion, indicating that this was the most important choice she needed to make. She maintained a good level of task completion on follow up. She continued to do math problems correctly, but the issue of making mistakes was neutralized. The teacher also scored her math papers according to the number of correct problems rather than subtracting for number wrong. Terri was allowed to accumulate total correct responses toward each quarterly grade. She learned that if she did not do well on one paper, she could improve her overall score by doing well on subsequent papers. This seemed to help maintain her reduced anxiety about making mistakes in math. The teacher continued to apply the choice strategy with Terri in other academic areas. Her overall productivity level improved gradually during the school year. She did not become an honor student, but she did earn passing grades.

Nathan...The Boy With No Choices

Nathan is a first grade boy who was referred because he was doing nothing in class. He would stuff worksheets in his desk and knapsack and never complete them. His teacher did not question his ability or skill, he simply did not want to do the work. Classroom observation indicated that during classroom work time, Nathan liked to play. He would draw or color or play with small toys he had brought from home. He would visit with classmates and wander around the room, but typically did not cause disruption in the classroom. Most of time, when Nathan was given unsupervised work time, he preferred to play and did not do assigned work.

His parents had been informed of this problem by the teacher, and had gone overboard on the supervision at home. During my interview with them, it turned out that Nathan was their first and only child and they had very high expectations for him. Because of his "immature" behavior at school, they had gone to extreme lengths to structure his time at home. Until his grades improved, Nathan had no playtime, TV time or unstructured time, nor was there any way for him to earn any until the next report card, 6 weeks from now. He was given assignments at home to do in reading, math and spelling by his parents, because he had stopped taking his real homework home. The teacher was frustrated because she did not realize what was happening and Nathan was very distressed at having to do all the additional work. Nathan had very few choices at home, so when he came to school and had more freedom, he chose some playtime and recreational time for himself. Without realizing it, his teacher and parents had been cooperating to maintain his problem.

In this case it was essential to work with Nathan's parents regarding choice awareness. They were puzzled to hear that Nathan had a problem making decisions because he essentially was given little opportunity to do so. As we discussed his and their behavior patterns, they began to realize that they had created a home environment which did not allow Nathan to learn how to make good choices. Therefore, when he went to school and experienced less supervision and more behavioral options, he didn't know how to handle it appropriately. We did some academic testing which reassured his parents that he was learning in spite of the behavioral problems. They agreed that they were OD on the ruling choices and were receptive to a behavior plan to help teach Nathan how to make better ruling choices for himself.

Together, we listed the behaviors they expected of Nathan at home. Then we looked for ways to add a structured choice factor to each of these behaviors. For example:

1.	Doing homework:	Nathan must do 30 minutes of homework each night. He could choose to do it before or after supper and he could make this choice each day. A timer would be used to monitor the 30 minute period.
2.	What to wear:	Mother would select three shirts and Nathan could select which of the three he would wear.

3. Taking a bath:	Nathan had to take a bath each day. He could now decide whether to take it at night before bed or in the morning before school.

Additional items were included and eventually a list was agreed on by Nathan and his parents. Nathan was to be allowed play time at home if he held to his part of the agreement; i.e., did his homework, took a bath, etc. His parents agreed to accept his decisions and not to object or overrule him. Nathan was especially excited about having more free time and less work time at home. We also explained that Nathan needed to make better choices about work time at school. The teacher agreed to send home a daily note about the choices he had made each day relative to doing his work. If he had three good notes each week, he could do something special on the weekend. Eventually this was faded to one note per week because of the improvement in Nathan's behavior and productivity.

Several follow-up meetings were held with parents, Nathan, teacher and this psychologist. Nathan's attitude had improved and he had increased daily productivity. His parents had found more ways to structure choices for him and Nathan was responding positively to having more freedom at home. The weekly notes were continued and Nathan still needed reminders to get busy during the day from his teacher. Nathan's attitude was the most noticeable improvement and his parents were more relaxed about setting limits for their son.

Conclusions and Considerations

Working with parents, children, and teachers from the perspective of choice awareness has been a rewarding and successful approach to effective behavior change. My experience has been that even the most ineffective parents do make some choices about their children and taking control over just one of those choices is often the place where they can successfully begin. Parents, children and teachers understand the concept of OK and OD and thereby have a perspective from which to evaluate the choices they make. The five kinds of choices: Caring, Ruling, Enjoying, Sorrowing, and Thinking/working, provide labels or categories for people who often don't carefully attend to or understand their own behavior. The acronym CREST also makes it easy for them to remember. As evident in the case illustrations, it was not necessary to explain the entire system to all parties in order to make effective use of it. What seemed to happen in all three cases is that the parties paid closer attention to their behavior and more readily monitored the effect of what they said on the people with whom they interacted. Before using the CREST system, I found myself advising parents along the same lines, but without a common language to describe/explain events and determine what was working and what wasn't. The CREST system gave us a common language which really facilitated our ability to plan and implement more effective behavior interventions.

Another positive feature of this system is that all parties do not have to actively cooperate in order for change to occur. This was especially true in Terri's case. Terri's mother was herself a perfectionist and it would do no good to encourage her to help her daughter learn to make mistakes at home. Prior to using the choice awareness approach, the situation would have appeared hopeless given the mother's high degree of resistance to change. However, with a cooperative teacher who was willing to risk an innovative approach, Terri was able to learn how to make mistakes within the learning situation. That is really what we wanted to occur anyway, so behavior change within the home setting was not critical. Choice awareness helped us structure the intervention so that Terri and her teacher were clear on what was to happen. Identifying Terri's choice habits within the classroom setting was a relatively available approach and required only passive agreement from her mother. Choice awareness provided a strategy for both problem analysis as well as an effective behavior intervention.

The chief task of the psychologist in choice analysis is to determine who is making what choices and when. The techniques for collecting the needed information are basically interview and conferencing techniques, something school psychologists are generally accustomed to doing. In most cases it is necessary to interview all the parties involved usually parents, teacher and child. In the case of Nathan, this procedure was able to clearly put us on the right track in development of choice awareness for Nathan and his parents. The teacher did not have to significantly change her approach at school, so the focus in this case shifted to the parents. Without the interview and conference with the parents, it would not have been clear that Nathan's resistance was to events at home. Choice awareness theory also provided a perspective from which to interview the parents. As I repeatedly inquired about decisions Nathan made at home, his parents began to realize that he had very little opportunity to make meaningful choices. They did not see the changes I asked them to make as relaxing their control of Nathan, but more as restructuring it. This made it more acceptable to them and the changes did not seem so significant. Coaching was needed to help them find additional ways to structure choices for Nathan. However once they began to see positive results they were much more amenable to future changes. The most helpful realization for Nathan's parents was that of OK vs. OD choices and then learning to moderate their behavior with Nathan.

The final point about using choice awareness theory is the flexibility across age groups and situations. Bonnie was making choices similar to the younger students, however there were more variables to consider. The issue of special education, grades and peer relationships were all present at a high level of awareness in Bonnie's case. She was also better able to identify and describe the choices she was making and could connect her choices to the negative outcome she was producing. Her mother realized the need to stop making OD caring choices with Bonnie, and our intervention gave her a means whereby to do that. The monitoring methods of teacher reports on a weekly basis were very helpful in providing feedback. It was a means for Bonnie to be held accountable for her choices and to examine her choices on a regular basis. It was also a way to talk with Bonnie about her relationship patterns with peers. Merely writing down her behaviors helped Bonnie become aware that she had made choices regarding peers and that she was responsible for her part of the negative peer interaction patterns. The interventions with Bonnie were structured around parent/teacher/student interview and required nothing out of the ordinary on the part of teachers as teacher reports are a common request in this junior high.

Overall, Choice Awareness theory is a helpful technique for the school psychologist because it provides a means of problem analysis which is relevant and concrete. It provides a common language and a simple evaluation system which parents, students and teachers seem to understand. It seems especially useful in the school setting as an aid to developing interventions which are tailored to meet each situation. The skills required of the psychologist include careful listening, observation and consultation skills. Individual testing is purposeful when utilized and can frequently be incorporated into the overall behavior plan. Monitoring methods are relatively simple and usually directly linked to systems already being used by teachers such as daily notes home, weekly reports, and grades. As with any theory or system, it is not a panacea for all behavior and learning problem situations. However, the focus on decision making skills and learning to control choices is effective because it gives the child, parent, teacher and school psychologist responsibility for the choices they each make and the consequences that result. Choice awareness theory integrates the affective and cognitive aspects of decision making and provides the system and structure for teaching children, their parents and teachers better decision making skills.

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Preschool Screening Programs

A Challenge for Decision-Makers

Barry J. Wilson

Abstract: Problems and possibilities of predicting school readiness and school success are reviewed. Intervention alternatives are explored. A case study is provided.

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Introduction

Attempts to identify preschool children who are likely to encounter difficulties in school learning are analagous to the age-old problem of deciding which melon in the melon patch is "just right" and which are likely to be "not ready". Rumors abound that there are semi-scientific methods of identifying good melons and good students. Most melon-thumpers will admit that they are occasionally wrong and the same is true of those who attempt to study children. Essential characteristics are often convert and decisions are typically made on the basis of interference. Knowledge of growing conditions can be helpful in either situation and some "problem" melons and children are more detectable than others. The decisions to be made about children are more complex, difficult, and of far greater import to society. Thus our attempts to develop and refine decision strategies for children that go beyond folklore are of major significance to educators and to children.

Most school psychologists are accustomed to participating in decisions made about preschool youngsters on an individual basis. These decisions are typically made in response to questions posed by parents and teachers. "Is my child ready for kindergarten?" "Do you think Billy is hyperactive?" "I think that my child is gifted. Can you evaluate her to find out?" Many parents ask such questions of us because they are concerned about making the right choices for their children and providing the best possible environment for the optimum growth and development of the child. School psychologists are perhaps less likely to be directly involved in preschool screening that is conducted on a group basis. The two situations are similar in that there are often important questions to be answered and important decisions to be made about children. Consultation with parents, teachers, and children regarding these important decisions requires an understanding of preschool assessment and intervention strategies. The intent of the present chapter is to provide guidelines for better decision-making at the preschool level. The specific context for the chapter is that of preschool screening although the ideas presented have implications for individual situations as well. The screening context is also important in that it will be argued that preschool screening programs need to be evaluated at the local district level and school psychologists, by virtue of their training and interest in research and evaluation, can often provide valuable technical assistance in accomplishing this important task.

The topic of preschool screening is broad enough to be treated in a book and indeed there are two recent volumes that do so (Barnes, 1982; Lichtenstein & Ireton, 1984). As Barnes notes, preschool screening is only one component of an early identification/early intervention system. The other components include case finding (also referred to as child-finding), diagnosis, and follow-up assessment. Preschool screening can be defined as:

> the application of a series of observational and measurement procedures used to identify those children in the general population who may be at-risk (italics added) for a specific disability or who may otherwise need special services or programs in order to develop to their maximum potential (Barnes, 1982, p. 11).

Preschool and kindergarten screening programs have become increasingly popular among school districts (Mercer, 1983). As Lichtenstein and Ireton (1984) noted, current interest in preschool screening is due in part to Public Law 94-142 as well as the impact of psychologists such as Bloom, Hunt, and Kirk who have stressed the importance of early child care and stimulation. Screening programs have been justified by the idea that early identification of learning problems may allow appropriate intervention to be made so that these problems can be prevented or alleviated (Satz & Fletcher, 1979). While this goal is generally viewed as commendable, a number of investigators have pointed out the potential dangers of making such predictions (Keogh & Becker, 1973; Lichenstein, 1982). Screening instruments and procedures can be inaccurate, may not provide information that is helpful for intervention, and the intervention itself can be ineffective or potentially harmful. These potential problems need to be addressed in evaluating screening programs at the local district level. The two major questions to be answered in such an evaluation are (a) How accurate are the screening procedures? and (b) Does the screening result in effective intervention.

The Prediction Problem

The question of predictive accuracy is typically addressed through some type of manipulation of numbers. While self-delusion with numbers is by no means an exclusive domain of preschool screeners, let alone psychologists, studies in the area of preschool screening provide numerous examples of what might be termed "numerical creativity". The following section is intended to describe the primary ways in which we have entertained ourselves with the question of accuracy in preschool screening. Some suggestions are also made that are intended to add clarity to an issue that has often been confusing.

The determination of acceptable accuracy is not a simple task and review of the current literature suggests considerable variation concerning acceptable indices of predictive accuracy. For example, Glazzard (1980) concluded that a reading readiness test and a kindergarten rating scale were acceptable predictors of reading achievement in first through fourth grade. The correlations that she reported were indeed statistically significant from zero correction but virtually identical to those reported in an earlier study by Eaves, Kendall, and Crichton (1974) who were much more pessimistic with respect to the instruments used in their study. Similar contrasts in conclusions characterize studies that report predictive efficiency in terms of hit rate (i.e., per cent of children correctly identified). Mercer, Algozzine, and Trifilletti (1979) pointed out that many studies have reached conclusions about predictive accuracy on the basis of incomplete analysis of data. Satz and Fletcher (1979) also argue that many studies fail to use any systematic criteria to gauge accuracy. These difficulties have prompted Keogh (1977) to describe conclusions made about predictive accuracy in early identification as "selective perception".

While subjectivity is always an element in evaluation, problems in assessing predictive accuracy can be addressed by a) clear specification of target populations; b) careful selection of screening instruments; c) awareness of the limitations of our prediction methodologies; and d) the judicious use of prediction criteria. The following discussion is intended to clarify the importance of these four items but it should also be noted that a state of perfection is more easily described than attained.

The Target Population.

While it is important for preschool screening to have a clearly defined purpose, such is often not the case and this results in difficulty in defining target populations. If, for example, we say that the purpose of a screening program is to identify children who are "at-risk" we have not clearly identified a target population. What precisely are the "risks" that face the "at-risk" preschool child? Is it the risk of becoming below average in one or more school subjects? The risk of being seen as inattentive and/or disruptive in the classroom? The risk of being described as learning disabled, mentally deficient, or emotionally disturbed and thus requiring expensive intervention at a later date? If we fail to be clear about the risks we are attempting to predict, we cannot be clear about what we mean when we say that a preschool child is at-risk and several authors have questioned the utility of the term. The specific purposes of screening programs can often differ from district to district because of contrasts in preschool programs, resources available, and characteristics of the general population to be served.

Screening Instruments.

The selection of a good screening instrument or procedure would appear to be an important consideration. The search for a "valid" screening instrument has produced both large numbers of studies as well as great numbers of screening instruments. Southworth, Burr, and Cox (1980) reviewed "nearly 1000 instruments" and provide brief descriptions of 250 of them. Johnson (1979) was somewhat more restrictive in terms of numbers but describes important characteristics of 130 preschool tests. These reviews are good sources of descriptive information about preschool tests in terms of content, costs, and publishers. Lichtenstein and Ireton (1984) and Barnes (1982) provide more detailed summaries of screening instruments but also evaluate the merits of these tests on the basis of reliability, validity, cost, length, and empirical studies. Many instruments intended for preschool screening have been recently developed and have yet to demonstrate their value. There is, of course, no benchmark task that can be applied to screening tests that yields a clear index of comparative worth. As Lichtenstein and Ireton note, situational factors such as program characteristics need to be taken into account. While there are numerous instruments available, many can be eliminated from consideration when they fail to meet program needs or are clearly deficient from a psychometric standpoint. Most districts have already adopted particular instruments or procedures for screening and unless these are clearly deficient and inappropriate, it would be wise to evaluate their merits before replacing them (Wilson & Hewett, 1977). Continuing empirical validation at the local district level is desirable and requires a clear understanding of prediction methodologies and criteria that can be used to judge the accuracy of screening.

Prediction Methodologies

Validity coefficients. Most of the studies that have attempted to validate screening instruments or procedures have computed a validity coefficient between the screening test or procedure and an outcome measure. While the predictive validity coefficient can have some utility in the selection of a test or procedure, there are also some limitations that may be illustrated by returning to the melon patch analogy. One could be informed by a sage melon farmer that the Three-Thump test has a correlation of .68 with taste ratings by a panel of melon gourmets. The information is less than informative when the consumer is interested only in the odds of getting a good melon. In the case of preschool screening, the fact that a readiness test correlated .73 with second grade reading scores doesn't tell me directly whether I could use the readiness test to select students for a special pre-reading program. Validity coefficients focus attention on the congruence of test or rating scores without clarifying the degree that selection decisions made about individuals are valid. The purpose of most screening programs has been to select some students for what is hoped to be appropriate educational intervention and it is the selection and decision process that needs to be validated. Studies that report only validity coefficients do not directly address selection and decision variables although the fundamental question of test validity may well be one of several important considerations.

Prediction and Hit Rate. Assessment of predictive efficiency has also been reported using other prediction models. Currently, the most prevalent of these is the prediction-performance matrix. Figure 1 displays the typical 2 x 2 matrix: (from Mercer, Algozzine, & Trifiletti, 1979).

		OUTCOME	
		POOR	GOOD
SCREENING	POOR	PREDICTED POOR PERFORMANCE POOR true positive	PREDICTED POOR PERFORMANCE POOR false negative
	GOOD	PREDICTED GOOD PERFORMANCE POOR false positive	PREDICTED GOOD PERFORMANCE GOOD true negative

This model was originally proposed by Meehl and Rosen (1955) and has influenced the work of a number of researchers in the early identification area (Satz & Fletcher, 1980; Barnes, 1982; Lichtenstein & Ireton, 1984). The model has been influential in selection procedures and research in the areas of clinical and industrial psychology. The model directs attention to decision efficiency. This model is deceptively simple, however, and can be interpreted (as well as misinterpreted) in a number of ways.

Screening outcomes are represented on the left side of the matrix and are designated "poor" and "good". The status of the individual on a subsequent criterion measure is indicated at the top of the matrix and in this case is designated "poor" and good". Depending on the specific decisions made in a screening program, these outcomes could be labeled more specifically as "special services needed" and "special services not needed" if the purpose of screening was to refer children for further assessment to determine eligibility for special programs. If a screening instrument or procedure is perfectly accurate, all students determined to be "poor" during screening would turn out to be "poor" or in need of special services and would show up in the cell of the matrix labeled "true positive". Likewise, in such a state of perfection, all students designated as "good" during screening would turn out not to need special services and would show up in the cell labeled true negative. In this ideal case, there would be no false negatives and no false positives and the overall hit-rate would be described as 100%. Such a state of perfection does not exist in practice. An example will help to clarify the ways in which hit-rate can be used to describe predictive accuracy.

Table 1 Data reported by Narnes (1978) for the Jansky Screening Index and the Gates Reading Test

		outcome		
		poor	good	
screening	poor	7	64	71
	good	1	94	95
		8	158	

Table 1 shows a portion of the results obtained by Barnes (1978) in a study of the cross-validation of the Jansky Screening Index. Studies using this model report results in terms of a hit rate where hit rate is defined as the percentage of children correctly classified as at-risk or not at-risk. An overall hit rate is the number of true positives and true negatives divided by the total sample. In this case, the overall hit rate is 7 + 94/ 166 = 61%.

Hit rates for the percentage of valid positives, false positives, false negatives, and true negatives are also often reported. As Mercer, Algozzine and Trifiletti (1979) have pointed out, these hit rates can be computed horizontally or vertically with dramatically different results. These can be illustrated by using the data in Table 1. We could speak of having a true positive hit rate of 7 out of 8 (88%) with the vertical method (using the column total as the denominator) or we could speak of having a valid positive hit rate of only 7 of 71 (10%) with the horizontal method (using the row total as the denominator). The valid positive percentage could also be reported as 7 of 166 using the total sample as the figure in the denominator although this computation is encountered less frequently in the literature. The fact that different methods of computating lead to different percentages has caused confusing in the literature (Satz & Fletcher, 1979). Gallagher and Bradley (1972) argued that it is better to use the horizontal method for computing false positives and the vertical method to describe the percentage of false negatives. Obviously each method yields different information as Mercer (1983) had indicated. Both horizontal and vertical methods can be useful in the interpretation of results. However reported, it is important that all data in the matrix be provided. In our example, it is clear from inspection of the matrix that virtually all the problem readers were detected by the Jansky Index (7 of 8) but of the 71 children declared to be at-risk or "poor", 64 of them turned out to be reading adequately or better. No matter how computed, there were few false negatives but many false positives.

The fact that different methods can be used for reporting hit rates does explain some of the conflicting findings reported in the literature but it is also evident that some researchers may have been selective in reporting results and have not always provided the necessary data for the reader to understand the basis for the hit rates reported. The situation is not aided by the recent publications by Barnes (1982) and Litchtenstein and Ireton (1984) who provide conflicting methods for computing hit rates for true positives (also referred to as "sensitivity") and true negatives (also referred to as "specificity"). It could be argued that the method to use might well depend on how you wish to impress someone about the effectiveness of your screening procedures.

F[illegible] ffecting Hit Rate. The relative simplicity of the hit rate model is further clouded by the fact that predictive efficiency is signiicantly affected by base rate and selection ratio as well as test validty (Wiggins, 1973; Anastasi, 1982). Base rate is defined as the incidnce of a particular condition within a population. The base rates of cetain conditions can be determined with a certain degree of objecivity (e.g. incidence of deafness in a school-age population). In the cse of learning problems, the determination of base rate is a much more subjective decision for reasons described in the previous section on targe populations. If, for example, one were to attempt to screen for studets who are learning disabled a base rate of 3 to 5 percent might well e appropriate. Attempting to screen for children who have later readig problems might well result in a base rate of 20% to 30% or more depeding upon district characteristics and the criteria used to classify a chid as a "poor reader". In another situation, one might attempt to scree to detect students who would later be retained in grade during the primay years. Depending on district policies and teacher preferences regading retention, the base rate for retention could fluctuate rather dramtically.

election ratio is defined as the percentage of students identified as at-rsk. Just as the determination of base rate can be somewhat subctive and influenced by district characteristics and criteria emplyed, selection ratio is also often arbitrary. Selection ratio is typally determined by failure to meet a previously determined cut-off scor on a screening test or battery. These test results may be augmented by her observations by teachers, parents, and other professionals. Ther is considerable variation in the selection ratio reported in the litrature. These variations can markedly affect hit rate as we shall obseve. This was also demonstrated by Barnes (1982) using the data from Tab 1. When the selection ratio was dropped to 15% by using a different cutff score for the Hansky Index, overall hit rate improved to 90% with onl 15 individuals who were false positives.

Crieria for Assessing Hit Rate

The influence of base rate and selection ratios are best observed by looing at criteria used to assess hit rate. It should be noted, however, tha most studies on early identification have only reported hit rates (soetimes selectively) and have not used any particular criteria for juding their merits. Under these circumstances, the naive reader has few ancor points to make sense of a hit rate of, say, 85%. One can observe tha 85% is less than perfect (100%) but much greater than 0% and better tha 50%. Several criteria can provide better reference points for juding the effectiveness of screening procedures.

The Base Rate Criterion. The base rate can yield a rather useful but severe criterion particularly when the incidence or base rate is low. If, for example, it is accepted that the incidence of learning disabilities is 3%, it would not be difficult to devise a prenatal test to detect learning disabilities with 97% accuracy. If everyone were to be declared to be OK by this fictitious test, the test would be inaccurate only 3% of the time and no money would need to be spent on an intervention program. The point of the example, of course, is that any screening procedure that does not improve over base rate prediction is open to criticism. While prediction from base rate was mentioned by Meehl and Rosen (1955), few studies have examined the question of whether screening procedures have improved on prediction derived from base rate. Failure to meet this criteria does not in itself suggest that a screening procedure is of no value. Prediction from base rate would result in no one selected for intervention. When intervention results in significant improvement for those selected as at-risk, benefits could outweigh the costs. Failure to meet this base rate criteria does, however, suggest a need to more carefully consider the implications of decisions made on the basis of screening procedures.

Improvement Over Chance (IOC) Criterion. Additional information about predictive accuracy can be gained by asking how much better selection was obtained than could have been had by random selection. The percentage of valid positives that could be selected by random assignment is equal to the base rate (BR) times the selection ratio (SR). In the example cited in Table 1 above, the base rate was 8/166 or 4.8%. The selection ratio was 71/166 or 42.7%. In this instance, the percentage of valid positives that could be selected by chance is .048 * .427 = .02. The number of children who could have been validly identified by the Jansky Index is then 2% of the 166 children or in this case 3 children. The remaining cells in the matrix can be similarly computed. Table 2 presents the data from Barnes (1978) with chance estimates included in parentheses in each cell.

Table 2

Comparison of obtained and chance outcomes for Barnes (1978) data

		outcome			
		poor	good		
screening	poor	7 (3)	64 (68)	71	(SR=71/166 =42.7%)
	good	1 (5)	94 (90)	95	
		8	158	166	
		(BR=8/166 =4.8%)			

It can be seen that the number of valid positives (3) and number of valid negatives (90) that could be gained by chance assignment is not much worse than the results obtained by the Jansky Index. The overall hit rate obtainable by chance is 56% which compares with the hit rate of 61% using the Jansky Index. One can say that the Index resulted in 5% improvement over chance prediction. This criterion provides useful knowledge in that it establishes a lower limit for prediction. A screening procedure that has any validity at all will exceed chance prediction. As we shall see, chance prediction can become rather impressive under certain conditions.

Relative Improvement Over Chance. It is important to note that in a great many instances in the literature and in practice, the base rate and selection ratio employed are rarely identical and are often quite discrepant. This discrepancy has a significant effect on the upper limits of prediction since the overall hit rate can be 100% if and only if the base rate and selection ratio are equal (Wiggins, 1973). The maximum possible overall hit rate is equal to 100% minus the discrepancy between base rate and selection ratio. In the example cited above, the selection ratio was 42.7% minus the base rate of 4.8% yields a discrepancy of 37.9%. Thus in this case, the maximum possible correct would be only 62.1%. Thus the actual hit rate obtained using the Jansky Index was 61%. This was only 5% better than chance but it was only 1% less than what was possible given the discrepancy between the base rate and selection ratio employed. As noted above, when Barnes (1982) adjusted the cut-off for the screening test, much better results were obtained.

Loeber and Dishion (1983), in a review of studies that predict delinquency, point out that percent improvement over chance (IOC) always falls between the chance value and the maximum possible correct. Since studies vary with respect to maximum possible due to discrepancies between base rate and selection ratio, comparisons across studies are difficult to make. They proposed an index called Relative Improvement Over Chance (RIOC) to provide a better basis for comparison. The formula for this index is: RIOC = (%IOC / %MC- %RC) x 100 where MC is maximum possible and RC is random correct percentage. This concept would appear to have useful application to the assessment of screening accuracy.

Communicating About Predictions

While the use of the hit rate model and hit rate criteria can aid in the evaluation of a screening program, psychologists and researchers are also responsible for communicating with teachers, administrators, and parents regarding screening results. While psychologists and researchers are easily entertained by hit rates, IOC's, and RIOC's, these concepts have been known to produce confusion, frustration, and often drowsiness among the public with whom we attempt to communicate. Better communication and clarity can often be obtained by reporting screening results using expectancy tables (Wilson & Hewett, 1977). Such a format can also be helpful in clarifying the utility of a screening procedure. Table 3 presents an example of an expectancy table. Detailed but simple instructions for the preparation of such tables can be gained from Wesman (1966). When large numbers of students are involved, such information can be more quickly obtained by using a statistical package which provides routines for cross-tabulation. The advantage of this format is that it expresses predictions in terms of a probability which serves as a reminder to all concerned that no outcomes are absolutely certain. This concept, of course, can be expressed in many ways and can be gained through a number of statistical techniques. The advantages of using an expectancy table are that it can be presented graphically in a manner that is relatively easy to comprehend and discuss with parents and teachers.

Table 3

Illustration of an expectancy chart for scores on a screening battery for a sample of preschool students. (Adapted from McCormick & Ilgen, 1980).

```
RANGE OF
SCREENING
TEST
SCORES
              _____________________________________________________
103-120       |*********************************************** 94
95-102        |*****************************************82
93-94         |**********************************68
87-92         |*************************** 53
60-86         |************ 25
              |
              |_____________________________________________________
              0        20        40        60        80        100
                     PERCENT OF STUDENTS
                          ACHIEVING
                      AT GRADE LEVEL IN
                        SECOND GRADE
```

Intervention Effects

While much has been said at this point about predictive accuracy, it is obvious that predictive accuracy in screening is of no significance unless the predictions result in better educational opportunity for children (Wilson & Reichmuth, in press). Ebel (1979) has suggested that the continuing fascination about predictive validity is like raising a stir in the dust and then complaining that we can't see. We are bound to discover that our predictions are imperfect. The search for perfect predictive validity has resulted in considerable dust stirring and numerous complaints that our predictive foresight is less than 20/20. As Ebel notes, test scores are best used to encourage success rather than predict it. In the context of preschool screening, the question becomes that of whether screening encourages the success of our students through effective intervention.

Historically, the education of children of preschool age has been the responsibility of parents and indeed that continues to be the case for many of our children. The purpose of preschool screening should be governed by the type of intervention that can be provided. There are clear economic constraints for most school districts in terms of the intervention options that can be offered. There are also somewhat conflicting views about what kinds of intervention are appropriate and necessary. The present discussion of intervention effects will touch upon three views about intervention that have influenced practice: (a) the early enrichment view; (b) the readiness view; and (c) views about the education of handicapped preschoolers.

Early Enrichment

Arguments by psychologists for early enrichment were made very dramatically by Bloom (1964) and Hunt (1961) and provided a rationale for numerous early intervention programs in the '60s including Project Head Start (Lichtenstein & Ireton, 1984). It is clear that the original expectations for Head Start were overly optimistic (Datta, 1983), and indeed the widely quoted statement of Bloom's that "50% of the (intellectual) development takes place between conception and age 4" was an inaccurate description of the data he was interpreting (Bloom, 1964, p. 88). It is important to note that there has been a significant shift among developmental psychologists in recent years regarding the efficacy of early experience. While these views may not yet significantly affect the perceptions of many practitioners and policy makers, the fact that serious question of the earlier assumptions represent a significant change in thinking (Clarke, 1984).

Clarke (1984) presents rather impressive arguments as well as a review of literature to suggest that early experience *by itself* has no *necessary* long term effect on later cognitive development. She further suggests that "most humane environments are sufficient to potentiate the normal development of intelligence" (p. 151). Thomas (1981) provides similar arguments for general psychological and social functioning. Such views provide a clear challenge to fundamental assumptions and theories about the unique importance of early enrichment.

Evaluation studies on the effectiveness of preschool intervention programs have also indicated that the positive effects of early intervention may not be as great or as durable as had been originally hoped (Lazar & Darlington, 1983). The most impressive source of data on lasting effects of preschool intervention has been the Consortium for Longitudinal Studies. A current summary of the work of the Consortium is provided by Lazar and Darlington (1983). While there are differences of opinion among individual investigators who make up the Consortium, Lazar (1983) presents a summary of findings that suggest the following outcomes:

1. Preschool programs increase individual scores on intelligence tests and these increases remain statistically significant for a three to four year period after the preschool experience.

2. During most of the elementary school years, arithmetic and reading achievement scores of program graduates are higher than those of controls.

3. Preschool graduates are less likely to be placed in special education or remedial classes than are their controls; they are more likely to meet the ordinary requirements of the schools and graduate from high school.

4. Preschool graduates have a higher self-esteem and value achievement more than controls. Their parents have higher occupational aspirations for them than control parents—or the children themselves. The program graduates have higher occupational aspirations as expectations than do their controls, and these are predictive of their actual attainments.

5. Indirectly, the preschool experience increased labor market participation in late adolescence and the early adult years. (Lazar, 1983, p. 461).

One additional finding that is of interest is the fact that there was no specific curricula or type of program that appeared more effective than another. Home-based, center-based, and combination programs were all effective in producing program/control differences (Lazar, 1983).

While these findings have been based upon studies of children who were economically disadvantaged and cannot be generalized in total to the general population of preschool children, there are implications that are clearly relevant to the assessment of any type of preschool intervention. First, multiple outcome measures need to be considered. Of particular relevance to programs intended for "at-risk" children is the question of whether these children are likely to require special education services or be retained in grade during elementary school years. (There is some evidence that once identified as "at-risk", children are more likely to require such services (Cooper & Hebbeler, 1984)). Affective variables and achievement motivation may also need to be considered. Second, the search for the "perfect" curriculum or intervention method may not be as relevant as is sometimes thought. There are very likely many intervention strategies that accomplish the basic task for providing enrichment for preschool children. Finally, dramatic and long lasting impact of preschool intervention may be difficult to detect without careful study.

Studies that have evaluated the effects of preschool enrichment for children seen as "at-risk" have been hampered by the fact that it is typically impossible to establish a clear comparison between students who receive special intervention and those who do not. While this problem is typical of attempts to assess special education programs, it does not prevent scrutiny of the outcomes of screening to determine that these outcomes are at least as "enriching" as outcomes that would have happened without the screening. A crude but not entirely unknown example is the case in which screening is conducted, students are labeled as "at-risk" (or some other less than complimentary term), but then given no assistance whatever.

The impact of an enrichment view can be seen within the State of Iowa as districts consider the merits of establishing full day kindergarten and at the time of this writing, there is discussion in the legislature concerning the possibility of providing additional state funds to support preschool opportunities for all children in the state. It remains to be seen if this proposal is realized.

Readiness

A somewhat competing view of intervention is proposed by those who argue that much of the failure experienced by children in the early grades can be explained on the basis of maturational lag. In this view, many children have learning problems because schools admit children for instruction on the basis of chronological age without assuring that the children are mature enough developmentally to handle the tasks required in school. This view is very popular and has engendered continuing debate about the age at which children should be allowed to begin first grade. Entry is typically allowed only at the beginning of the school year for administrative convenience but the age of admission differs by five calendar months among the various states (Educational Research Service, 1975). Iowa is among those states who have adopted September 15, as the "magic date" and thus admits students who are chronologically as much as five months older than children who are admitted in states where the date is set as late as February.

There is no question that the admission of students on the basis of age is arbitrary but there is some dispute about what to do about it. Proponents of readiness such as Ilg, Ames, Apell (1965) and Donofrio (1977) argue for delay in schooling and grade retention to promote readiness. Other investigators such as Gredler (1978) and Dietz and Wilson (in press), point out that increased chronological age does not necessarily result in better school attainment. Gredler proposes that schools should accept students and provide appropriate individualized instruction. A recent study by Langer, Kalk, and Searls (1984) provides ammunition for both positions. These authors studied National Assessment of Educational Progress data obtained in grades 4, 8, and 11 for 17,000 students. Results indicated little differences in scholastic achievement between older and younger students but younger male students were much more likely to be retained in grade at some point.

The influence of the readiness view can be seen in preschool screening programs that are essentially intended to detect readiness for instruction. Those children who are seen as "not ready" are then asked to delay entry to school or to the next grade level (i.e. be retained in grade), or to enroll in special sections of kindergarten that are intended to promote developmental readiness. Some districts have also provided what are often termed "transition" rooms to provide greater flexibility in the number of years of primary school available to students. There is conflicting evidence concerning the effectiveness of such programs (Leinhardt, 1980; Andreasen, Wilson & Hewett, 1981).

Education of Handicapped Preschoolers

Public Law 94-142 has provided an additional dimension to preschool intervention by providing a free and appropriate education for handicapped children ages 3 to 21. As Lichtenstein and Ireton (1984) point out, P.L. 94-142 has provided an unprecedented wealth of services for preschool age children, but requires that school districts classify students into various disability categories so that handicapped can be counted and districts be reimbursed. While the problems of labeling and classifying has been troublesome enough in providing special services to students of any age (Hobbs, 1975); Reynolds, 1984), the labeling and classifying of preschoolers offers specific problems that are somewhat unique.

Historically, the primary concern in preschool assessment was the identification of mentally deficient children (Kelley & Surbeck, 1983). The introduction of Head Start programs in the 60s together with the challenge of P.L. 94-142 has suggested a great need for a broad array of preschool assessment instruments. While there has been significant improvement in the numbers, quality, and diversity of preschool assessment instruments, the reliability and validity of many recently developed instruments remains questionable (Paget & Bracken, 1983).

As Paget (1983) points out, preschool children often require special skills and understanding on the part of examiners. Young children often find it difficult to adapt to the evaluation situation and test results are often influenced by normal preschool characteristics such as distractibility, fatigue, restlessness, shyness, and dependency. Additional problems may be posed by handicapped preschool children who are not be able to respond to many test items because of their handicap.

Preschool assessment has often been viewed as an extension or school-age assessment (Kaufman, 1983). Thus instruments devised for preschoolers have often been extrapolations of instruments devised for school age children. There is a growing awareness that preschoolers are qualitatively different from older children and that the behavior and skills that might be abnormal for older children may often be typical or normal preschool development (Kaufman, 1983).

It can be argued that preschool intervention conducted within the confidence of P.L. 94-142 suffers from the same extrapolation of intervention strategies to a preschool population. The disability categories used for school age poulation (e.g. learning disabilities) are sometimes difficult to extend to a preschool population and indeed may well be inappropriate for that age range. Since the provision of special services is contingent upon categorization within these prescribed categories, provision of needed services would appear to sometimes require "creative" diagnosis on the part of psychologists and other members of a staffing team.

It can be seen that while P.L. 94-142 has provided a basis for intervention with preschool children that has not previously existed, it has also posed questions and problems that have not previously been in evidence. As Lichtenstein and Ireton (1984) suggest, the mildly handicapped preschool child would appear to have the best chance profiting from intervention that is designed to prevent later school problems, yet the requirements of labeling and classifying may pose potential risks as well as advantages.

In summary, while intervention is obviously the most important element in preschool screening, there are various assumptions about intervention that can lead to different types of intervention programs and strategies. A typical screening program can often be seen to be guided by one or more views concerning intervention. As the saying goes, the proof is in the pudding (or melon?), and individual districts are wise to sample the results of intervention efforts and evaluate outcomes.

A Case Study

It is unusual to find a school that is dissatisfied with its preschool screening program. Most screening programs provide information to parents and teachers that is seen as valuable. In most communities, the screening also serves a way of introducing parents and children to teachers and other school personnel. Most students are not affected in terms of placement or entry by screening programs. Additionally, when parents and teachers are involved in decisions about intervention, they are also likely to view the intervention as appropriate and effective. So long as assumptions about preschool screening and intervention are unquestioned, current preschool screening practices are likely to continue without much controversy, and also without improvement. Such improvement can occur only when the two fundamental questions of screening accuracy and intervention effectiveness are asked and evaluated at the local district level.

It must be acknowledged, of course, that the availability of resources can pose obstacles to the attainment of many laudable educational goals including the assessment of screening programs. Previous discussion of accuracy criteria (matrices, base rate, IOC's, RIOC's, expectancy tables) as well as conflicting ideologies concerning intervention may give an impression that the task is formidable if not unrealistic in the "real" world. The following case study may serve to illustrate that tasks that are difficult in theory are not always as difficult in practice—a surprising reversal of typical theory/practice relationships.

Reichmuth (1983) evaluated a preschool screening program that is used in a large midwestern city. Specifically, she was interested in the use of the program in four parochial elementary schools. The screening was done in April and May prior to the scheduled entry of children to kindergarten the following September. The screening battery used included the Developmental Test of Visual-Motor Integration (VMI), the Peabody Picture Vocabulary Test (PPVI), the Motor Activity Scale (MAS), and the Preschool Language Scale (PLS). Each child was seen individually by a six-member team that included two learning disability teachers, two kindergarten teachers, a physical education teacher, and a speech therapist. Three aides also assisted with the screening.

Normative data on the screening battery had been compiled by the city public school district and cut-off scores provided criteria for acceptable or unacceptable performance on each of the tests. Performance on these tests as well as informal assessment of attentiveness, cooperation, and other behaviors were used by the team to assign the children to one of four categories: (a) readiness adequate; (b) readiness adequate in most areas; (c) developmentally at-risk; and (d) at-risk and to be further tested for eligibility for special education services. Parents were notified if the child was assigned to categories "b", "c", or "d". Parents whose children were designated category "b" were given suggestions for activities that might assist weak areas and also told the areas of relative strength. Parents of category "c" children were advised to delay entry into kindergarten for another year but also advised that they could allow the child to enter on schedule if they wished. These parents were also advised that they could get a second opinion to assist with the entry decision. Parents of category "d" children were advised to have their child evaluated by a school psychologist for possible special placement because of severe problems noted.

Of the 164 children screened in the spring of 1980, Reichmuth was able to follow-up 113 children who were available in the spring of 1983. Of these 113 children, 67 had been designated category "a", 25 category "b", 19 category "c", and 2 category "d". The distribution of children in each category was very close to that for the original 164.

Predictive Accuracy

Two criterion measures were used to evaluate the status of the children in 1983: the Gates-Macginitie Reading Test and the Behavior Rating Profile (Brown & Hammill, 1978). Correlations between the four screening tests and the Gates ranged from .24 to .34 and the multiple correlation between the four screening tests and the Gates was .48. Correlations between the screening tests and the Behavior Rating Profile were not statistically significant from zero correlation.

Outcomes were also evaluated using the hit rate matrix. For purpose of this analysis, categories "a" and "b" were combined and are described as "ready" in Table 4. Categories "c" and "d" were also combined and designated as "at-risk" in Table 4.

Table 4

Results obtained by Reichmuth (1983)

	low achievement	high achievement	
"at risk"	8 true positive	13 false positive	21
"ready"	9 false negative	83 true negative	92
	17	96	113 (Total N)

Students were designated low achieving on the Gates if their scores were below the 50th percentile and high achievers if they were above that point. In Table 5, the same results are presented in terms of percentages. Base rate (BR) or in this case, percentage of low achieving readers, was 15% and the selection ratio (SR), in this case percentage of children designated at-risk, was 18.5%. When the percentage of true positives (7%) and the percentage of true negatives (73.5%) are added, the resulting overall hit rate is 80.5%.

Table 5

Obtained percentages obtained by Reichmuth given BR = .15 and SR = .185

	low achievement	high achievement	
"at risk"	.07 true positive	.115 false positive	(SR = .185)
"ready"	.08 false negative	.735 true negative	(1 - SR = .815)
	17 (BR = .15	96 (1 - BR = .85)	

Table 6

Percentage possible by random assignment given BR = .15 and SR = .185

	low achievement	high achievement	
"at risk"	.028 true positive	.157 false positive	(SR = .185)
"ready"	.122 false negative	.693 true negative	(1 - SR = .815)
	17 (BR = .15)	96 (1 - BR = .85)	

Table 5 presents a matrix which demonstrates the perentage of true positives and negatives that could be expected on the bais of chance given a base rate of .15 and a selection ratio of 18.5%. The overall hit rate obtained by random assignment is thus estimated at 2.1%. Improvement over chance (IOC) is about 8%. Maximum possble hit rate is 96.5% since there is only a discrepancy of 3.5% between he selection ratio and the base rate.

The accuracy of the screening can be presented graphcally as in Figure 2 where X represents chance prediction, Y represents prediction obtained, and Z indicates the maximum overall hit rate otainable.

Figure 2

Hit Rate Obtainable: Chance (X), Actual (Y), and Possible (Z)

```
                X        Y              Z
------50------60------70------80------90------100
              % HIT RATE (OVERALL)
```

These results, as well as the correlation data reported above, indicated that the predictive accuracy of the screening program could be improved.

Intervention Effects

While it is typically difficult to develop a perfect plan for assessing intervention, simple descriptions of pupil progress are often informative. Of particular interest in this case was the fact that of the 21 students whose parents were advised to delay entry into kindergarten, 8 entered kindergarten the following September on schedule. This offered an opportunity to compare outcomes for the 13 students who delayed entry with the 8 who did not. The results were somewhat surprising. Of the 13 students who delayed, 8 were reading in first grade at the 50th percentile or better. Of the 8 students who entered kindergarten on schedule and against the advice of the screening team, 5 were reading at or above the 50th percentile in the second grade. While these numbers are small, and while the two groups were not, of course, randomly assigned to treatments, when these outcomes are translated into an expectancy table and used to advise parents, the communication would have to be something like the following:

> "Mrs. Smith, we don't think your child is ready for school and suggest you keep him at home for another year. On the basis of previous children who have undergone screening, I can tell you that if you decide to enter the child into school on schedule, three years from now, there is approximately a 60% chance that he will be reading at grade level or better in second grade. If you keep him at home for a year, three years from now, there is approximately a 60% chance that he will be reading in grade level or better in the first grade."

It is, of course, quite unlikely that such a conversation would occur since the evaluation of the effects of kindergarten delay would suggest that delay did not produce dramatic differences in reading outcomes for students who performed poorly on the screening battery.

A similar analysis was done for the behavior rating profile and there was a slight tendency for children who delayed to be less likely to be perceived as having behavioral problems (1 of 13 for those who delayed, 3 of 8 for those who did not).

This description of intervention outcomes raised some question about the strategy to delay entry for kindergarten on the basis of this screening program. The fact that parents were advised that they could enter the child if they wished and could get a second opinion also suggested that consultation with parents about intervention decisions was of benefit. While parents legally have these rights, of course, it is sometimes difficult for us, as professionals, to respect the wisdom of their decisions. In this case, the wisdom of parents appears to have been largely validated.

The rationale for delay was clearly consistent with a readiness view. While this strategy may have had payoff for some children, it may not have been of help to others. An extreme, and obviously hypothetical case, may clarify the deficiencies of this particular intervention strategy. A child could have been kept in an attic by parents, been screened, found deficient in several areas, and advised, in this case, to go back to the attic for a year so as to be more ready.

The results obtained by Reichmuth provided information that suggested that both screening instruments and intervention options needed to be reviewed. These results also provided these schools with a point of comparison for assessing any future changes made in the screening program.

Summary

School psychologists are often asked to participate in decisions about individual preschool children. These decisions typically require accurate assessment information and may result in actions taken to insure the best educational environment for the positive growth and development of the child. School psychologists may also be asked to participate in preschool screening programs. These programs typically involve large groups of children but also have the intent of gaining information about the child that will be helpful to parents and teachers. By virtue of training and interest, school psychologists can provide valuable consultation and assistance to such programs.

Proponents of preschool screening programs assume that "high-risk" children can be accurately identified. This assumption is threatened by the fact that we are often not sure what state we are trying to predict when we speak of "high-risk" children. There are many screening instruments available for screening purposes and several sources were identified that provide a quick summary of content and purpose.

Predictive accuracy is usually expressed in numerical terms. Researchers in the area of preschool screening have discovered many ways to express their opinions in the form of numbers. Unfortunately, simple statements like "94 percent accuracy" can be misleading. Several criteria were reviewed which provide a context for evaluating such statements. These criteria allow an application of concepts like base rate, selection ratio, and test validity. Expectancy tables were proposed as a means of communicating screening results to parents and teachers.

Predictive accuracy in the absence of effective intervention is an unfortunate example of a "good news/bad news" joke. Intervention with preschoolers is guided by several views about early development. The early enrichment view suggests that a stimulating environment during the preschool years can have a lasting effect on later development. Experience with Head Start programs as well as changes in theoretical perspective have diminished claims and expectancies generated by the optimism of the 1960s. The concept of readiness has also been an influential perspective in early education but research has failed to validate some popular actions taken in the name of readiness. Finally, P.L. 94-142 has provided an impetus to assist preschool children with special needs. The law has provided the financial resources needed to fund many special services for preschoolers but requires the application of categorical labels which may have troublesome consequences as well as potential advantages for the individual.

A Final Note of Caution

If ignorance is bliss, those of us who concern ourselves about preschool screening have ample reason to be joyful. The two questions that have been posed in this chapter regarding the accuracy of prediction and the effectiveness of intervention require thoughtful reflection as well as careful analysis. Strong opinions about early intervention are in great evidence and these certainly indicate the concern and care for children that should characterize parents and educators. It is indeed appropriate that we take action in behalf of preschool children who are in need, but it is also appropriate that we evaluate the actions we take.

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Oppositional Behavior

Mary Grace Percival

Abstract: Description and definition of oppositional behaviors are discussed. Treatment strategies for effective reduction of oppositional behaviors are reviewed.

Chapter Outline

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Introduction

School psychologists are often challenged to attempt the modification of "problem" behaviors exhibited by children identified by parents and teachers:

> *Johnny stamps his feet and cries, "But I want some!" Tears begin to stream down his cheeks and his mother says, "I told you before, NO!" She grabs his arm, dragging him down the aisle while he kicks, cries, and points to his favorite candy on the shelf.
>
> *Ms. Jones asks Mary Lou to put her reading away and get to work on her math. Mary Lou ignores the teacher's request. Ms. Jones takes Mary Lou's book from her whereupon Mary Lou throws her math book on the floor.
>
> *Suzie's father asks her to set the table. She is watching T.V. and doesn't feel like moving. After several police attempts, her father turns off the T.V. Suzie explodes at this perceived injustice. "You can't make me. I won't do it!" An argument ensues where various threats are exchanged.
>
> *Everytime Sam's mother tries to stop him from racing around the living room she spends a good half hour cajoling, threatening, diverting, and restraining. Usually she is worn out, but Sam has gotten her to "play" with him for at least that half hour.

These situations depict what has generally been identified as oppositional behavior. Other, less frequently used, descriptors include noncompliance, disruptive behavior, and temper tantrums. The primary characteristic of these behaviors is that of resistance to some external exertion of control (Sailor, Guess, Rutherford, and Baer, 1968; Zeilberger, Sampson, and Sloan, 1968; Trieschman, 1969; Wahler, 1969; Hall, Fox, Willard, Goldsmith, Emerson, Owen, Davis, and Porcia, 1971; Nordquist, 1971; Ramp, Ulrich, and Delaney, 1971; Scarboro and Forehand, 1975; Forehand , Roberts, and Doleys, 1976; Plummer, Baer, LeBlanc, 1977; Solnick, Rincover, and Peterson, 1977; Hobbs, Forehand, and Murray, 1978; Harris, 1980; Wahler and Fox, 1980; Forehand, Breiner, McMahon, and Davies, 1981; Haswell, Hock, and Wenar, 1981, 1982).

These behaviors, however, are not necessarily identical in terms of either function or topography. Functionally, oppositional behavior allows the individual to avoid or escape a situation which is perceived as aversive and is thereby negatively reinforced. For example, when Mary Lou throws her math book on the floor, Mary Lou's teacher isolates her from the class. Mary Lou, then, has successfully avoided math class and throwing the math book has been reinforced (given that such behavior increases in the future). The occurrence of such behavior might also serve to increase the amount of attention received from others. Thus, oppositional behavior may be maintained by positive reinforcement. Sam's mother attends to him more frequently when he is misbehaving than when he is behaving appropriately. If his racing around the room continues and even increases even may be reinforcing it by extra attention. Finally, oppositional behavior might be described as the absence of cooperative behavior (Wahler, p. 168). If this is the case, the practitioner would be concerned with shaping new, more appropriate responses. Suzie might be praised by her father everytime she looks at him when he makes a request. Then, she might be praised everytime she looks at him and verbalizes her acquiescence, and so on until, step by step, Suzie learns to cooperate with reasonable requests, rather than engaging in oppositional behavior. Topographical differences are exemplified by the comparison between a child who silently ignores a parental request and the child who cries and kids upon the occurrence of a parental request. It is imperative that individuals attempting to modify such behaviors are cognizant of both the topography and function of the behaviors exhibited by targeted children.

School psychologists, as well as parents and teachers, are frequently faced with the necessity of dealing with oppositional behaviors. The present paper outlines assessment techniques and intervention strategies which have been utilized to control this problem effectively.

Assessment

Operational Definitions

Once it has been determined that the occurrence of a particular response is a "problem" that warrants intervention, it is important to operationally define of the behavior and a tentative goal for intervention. In reporting his problems with Suzie her father states that she is lazy; Mary Lou's teacher says Mary Lou is non-compliant; Sam's mother feels that he is uncontrollable. The problem with these descriptions is that they are vague and imprecise. Change can be more effectively programmed if the behavior to be modified is observable and measurable. One way to approach development of an operational definition and goal is to ask what would the child do or say to demonstrate less laziness? noncompliance? uncontrollability? The behavior to be changed is then stated as something which can be observed and measured: Suzie leaves what she is doing and begins the requested activity within 15 seconds of the command; Mary Lou stops reading at 10:00 and completes her math assignment by 10:30 each day.

Communication is much less ambiguous when the behavior to be changed and the changes sought are precisely stated. Then, all individuals involved are assured that they are talking about the same thing. It is also much easier to monitor the effectiveness of the intervention. Are changes actually occurring? Does Mary Lou complete her math assignments more frequently with less outbursts then before intervention was implemented.

Behavioral procedures will be most effective if the specific behavior is operationally defined and the situations in which it is to occur are identified. Thus, it is important to consider the dimension of the response that is the critical component. Sometimes the dimension to be specified is the topography of the response; that is, it's form and shape. In Suzie's case one might be concerned more with how she completes the task (the dining utensils are placed appropriately) than if she completes it in a timely fashion. With Mary Lou, one might not care at all that her math work looks like chicken's feet on the paper, but just that she hands in the assignment. The second dimension to be considered is that of intensity. Johnny might not throw a tantrum in the store very often, but when he does it is very loud and it continues until he leaves the store. In Suzie's case the acceleration of intensity as the confrontation continues might be targeted for change. The frequency of the response or how often it occurs might be the important dimension. How often does Mary Lou ignore a teacher's request. How many times a day does Sam race around the living room? A final response dimension of interest is that of duration: the length of time that a specific response lasts. For example, Johnny might begin a tantrum in the store that lasts until he is in the car for at least 15 minutes.

It is also important to consider these dimensions when one is outlining the responses required of a teacher and/or parent during intervention. The teacher is required to physically prompt a response rather than verbally prompt it (topography); the parent is instructed to praise the child softly rather than loudly (intensity); for every page of work the child completes the teacher is to give the child a star (frequently); the parent gives the child a hug for every 15 minutes that the child is walking quietly beside the cart (duration).

Methods of Data Collection

When the behavior to be changed has been identified it is necessary to develop a method of measurement. Such a devise will allow one to determine the intensity, frequency, and/or duration of the behavior, as well as the effectiveness of the intervention. It will provide all parties concerned with an objective picture of changes in behavior as they occur.

Behavior checklists are frequently used to aid in the identification of a specific response to be modified. A behavior checklist may include several topographically different responses or just one response. Table 1 provides an example of a checklist used by a teacher in a third grade class to assess several behaviors exhibited by a child in the class. It is an efficient method in that it merely requires the teacher to place a hash mark in the appropriate box each time the behavior occurs. This checklist provides information concerning frequency of response. Table 2 is a behavior checklist frequently used by teacher and psychologists in an effort to circumscribe the problem. Table 3 provides an example of a data sheet used by all staff in contact with a severely retarded four year old girl. She frequently engaged in tantrums. Each time a tantrum occurred staff were required to place a hash mark in the appropriate box. This system provided information concerning frequency as well as time during the day when tantrums were most likely to occur. Behavior checklists provide a simple and efficient means of data collection. This makes them especially attractive to teachers and parents.

In most cases it is not feasible or practical to expect a teacher or parent to collect data every minute of every day. Indeed, this is not usually necessary to get an accurate picture of what is going on. Behavioral samples can provide pertinent information without requiring a great deal of time and effort on the part of the recorder. If an independent observer is recording, more sophisticated time sampling methods may be utilized. For example, Wahler, et al. (1980) directly observed four subjects in their homes for 30 minute sessions. The recorders had ten seconds to observe and five seconds to record their observation for thirty consecutive minutes. One can imagine the reaction of a teacher if such a system were to be implemented in her classroom! However, one could ask a teacher to select a half-hour period in the morning and one in the afternoon during which she would keep track of the number of time the behavior occurs using a wrist counter. Another variation would be to divide the day into fifteen minute intervals and require the teacher/parent to record whether or not the behavior occurred at all during each fifteen minute interval.

If the behavioral dimension of concern is duration a more time consuming system may be necessary. The recorder may be required to observe the child for a thirty minute period and record the amount of time that the child engages in a specific behavior. Table 4 provides an example. The problem with this recording device is that if the behavior is of low frequency, an underestimate of it's occurrence might result.

It is important to remember that the record device utilized must be relevant to the identified problem. The response dimensions discussed above should be considered when designing a recording system as well as the feasibility of it's implementation. Finally, the goals of intervention must be taken into account. Very different recording system might be required depending on whether one is trying to decrease, increase, or maintain a particular response.

PERCIVAL --- OPPOSITIONAL BEHAVIOR

INSTRUCTIONS: Place a hash mark in the appropriate box each time the responses occurs.

Student: ______________________

RESPONSE	DAYS 1	2	3	4
1. Crying				
2. Talking Out				
3. Hitting, Biting Kicking				
4. Out of Seat Without Permission				

Comments:

TABLE 1: Behavior checklist. Frequency count of several behaviors.

PERCIVAL — OPPOSITIONAL BEHAVIOR

NAME ____ TEACHER _______________

NOTE: This checklist may be used to chart behavior for a week by drawing lines and labeling them with a day/date. It may also be used for several children as well. It can be used to indicate the degree of difficulty by keying "0" for not present, to "4" for excessive behaviors.

BEHAVIOR IN CLASSROOM	M 0	T 1	W 2	TH 3	F 4
1. Frustration reactions:					
a. Tantrum					
b. Crying					
c. Using profane language					
d. Pouting					
e. Destructive					
f. Explosive					
2. Poor adjustment to environmental change					
3. Poor adjustment to change to routine					
4. Response to Authority					
a. Disobedient					
b. Difficulty accepting criticism					
c. Resentful					
d. Defiant					
e. Stubborn					
f. Has little regard for rules, limits, punishments					
5. Behaviors related to class assignments					
a. Appears to be bored					
b. Does not finish work					
c. Attention wanders					
d. Constant need for teacher's attention					
e. Lacks self-sufficiency					
6. Annoying Behaviors					
a. Talks out loud					
b. Out of seat					
c. Does not raise hand					
d. Chews paper, erasers, etc					
e. Makes gutteral, crowing, etc. noises in classroom					

COMMENTS: (Example: Good week. Improving in 6a. Showing positive regard for others.)

TABLE 2: Behavior Checklist

PERCIVAL --- OPPOSITIONAL BEHAVIOR

Place a hash mark in the appropriate time slot
each time you observe a temper tantrum
Temper Tantrum: crying, screaming, kicking,
flailing arms and/or legs.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
8:00							
8:30							
9:00							
9:30							
10:00							
10:30							
11:00							
11:30							
12:00							
12:30							
1:00							
1:30							
2:00							
2:30							
3:00							
3:30							

Comments:

TABLE 3: Behavior checklist.

Frequency count and time analysis of single response.

PERCIVAL —— OPPOSITIONAL BEHAVIOR

Student: ______________________ Date: ______________________

Temper Tantrums: Crying and kicking/stamping feet.
observe for 30 minutes twice a day.

Record the time that the tantrum starts (Time-in)
and the time that it stops (Time out).

	Time-in	Time-out
1.	10:02	
2.	10:30	
3.	12:30	
4.	1:05	
5.	3:00	
6.		
7.		

TABLE 4: Sample duration recording sheet.

Controlling Variables

The phrase "terrible twos" conjures up images of parental dread. That parents begin to experience trouble handling children at this age is a universal given. Jenkins, Owen, Bax, and Hart (1984) provide data which support this cliche. Data were collected from parents regarding their child's behavior from birth to five years of age as part of a longitudinal study of health needs of preschool children in inner London. The prevalence of problems at different ages and continuities over time of common problems were reported (Jenkins et al., p. 76). 32% of two-year-olds sampled (N=298) were rated by parents as sometimes or frequently difficult to manage; 36% were reported as demanding a lot of attention; 50% were reported as engaging in temper tantrums once weekly to three or more per day (Jenkins et al., p. 83). There were basically no sex differences. Since temper tantrums were one of the commonest problems reported in subjects over two-years, the continuity of the problem was examined. Of the children having frequent temper tantrums at two-years, almost half were still having frequent tantrums at three; of those having frequent tantrums at three, 34 were still having them frequently at four and one-half years. Thus, if a child is engaged in tantrums at two years of age the probability of having tantrums at three is quite high. After three years the overall prevalence of tantrums falls (Jenkins et al., pp. 84-85). It is also interesting to note that at all ages, between 19% and 29% of children having frequent tantrums were also reported as demanding attention and difficult to manage as compared to 3% - 6% of the rest of the sample (Jenkins et al., p. 83).

Haswell et al. (1982) assert that oppositional behavior of children aged 18 months to six years is an important milestone of cognitive and emotional development. That is, the child gains the intellectual concept of negation ("no") and the realization of the self as a separate being (Haswell et al., p. 13). Furthermore, it is contended that the common function of any oppositional behavior at these ages is "to assert autonomy from adult control" (Haswell et al., p. 14). Haswell et al. (1981) found that parental inflexibility contributed greatly to the occurrence of oppositional behavior in the children. "The more inflexible the mother's behavior toward her child, the more frequently oppositional behavior occurred in response to the researcher's requests and prohibitions (Haswell et al., p. 442). In addition, the highest frequencies of oppositional behavior occurred when children were asked to cease an ongoing activity in order to begin a new one (Haswell et al., p. 443). Other causes of noncompliant behavior are outlined by Hilton (1982). Noncompliance was defined as ignoring a request, latency in responding, and/or performing behavior(s) other than those requested (Hilton, p. 2). It was noted that these behaviors were caused by attention seeking - in some situations noncompliance can be more rewarding than compliance; escape - noncompliance is more frequent when in demand situations than nondemand situations; and boredom - indicated by a decrease in performance from a previously high level (Hilton, p. 7-8). Analysis of the setting in which the oppositional behaviors occur may provide the necessary information as to which "cause" is operating (Hilton, p. 9). This is important because "the selection of an inappropriate intervention to one cause may strengthen the noncompliance if the behavior has a different cause (Hilton, p. 1). Harris (1980) provides a similar analysis of causes. He states that a child may "explode" for attention, in order to manipulate others, or out of frustration.

One or all of the aforementioned antecedent and consequent events may be operating at any given time. It is important for the investigator to identify the environment events that are maintaining the target response for purposes of intervention design. It is also important to remember that reinforcers are relative: one man's meat is another man's poison. One child's tantrums may be reinforced by the attention of significant others in the environment; another child's tantrums may be reinforced by escape from an activity the child does not want to perform. In each case a successful intervention will depend on the appropriate analysis of the events at hand.

Intervention

The intervention strategies outlined below have been selected for inclusion in this paper because of their demonstrated effectiveness in dealing with oppositional behavior. They are not meant to represent an all inclusive list. In the selection of an intervention one must consider the specific behavior to be changed, the response dimensions involved, the environmental conditions currently maintaining the response, and the goal(s) of intervention.

Restitutional Overcorrection and Positive Practice

A student who have overturned a desk is required not only to put it back in its correct position, but also to dusk and clean the desk. This is an example of restitutional overcorrection which requires the individual to restore the environment to a state much better than before the act (Sulzer-Azaroff and Mayer, 1977, p. 296). Positive practice overcorrection requires repeated practice of a positive behavior. Thus, the student who overturns a desk is required to dust and clean the desk as well as other desks in the room (Sulzer-Azaroff et al., p. 296). When no environmental disruption is created by an inappropriate act, only positive practice is applicable. Overcorrection minimizes the disadvantages of other punishment procedures and is educative. It provides rapid and long-lasting reductions probably because "new adaptive behaviors, apt to be supported by the natural environment, [have been] substituted for maladaptive ones" (Sulzer-Azaroff et al., p. 297). The overcorrection task should be directly related to the misbehavior in order to be effective in reducing the misbehavior (Sulzer-Azaroff et al., p. 298). As with other behavioral techniques, its application should be consistent and immediate. Finally, overcorrection will result in more rapid and lasting effects when combined with reinforcement of alternative responses (Sulzer-Azaroff et al., p. 300). More will be said about combination approaches later. The greatest disadvantage of overcorrection is that it requires the undivided attention of the parent or teacher which may not always be possible thereby precluding consistent application.

Time Out

In time out (TO) the access to reinforcement is removed for a particular time period contingent upon the emission of a response. The opportunity to receive reinforcers is removed: either the individual is removed from a reinforcing environment or the reinforcing environment is removed from the individual. For example, Johnny is engaged in a tantrum on the kitchen floor, screaming for cookies. TO could consist of mother leaving the kitchen with the cookies, or placing Johnny in his room. Other "common sense" type examples are provided by Sulzer-Azaroff (p. 282): Robert throws a paper clip, teacher sends him to stand on the cloakroom for awhile; the class becomes rowdy, all children are instructed to put their heads down for five minutes; a group of seniors paint a statue in psychadelic colors, they are suspended for a week.

The effectiveness of reinforcer isolation was compared with that of subject isolation in a study by Mansdorf (1977). A five minute reinforcer isolation was used to decrease the noncompliance of a moderately retarded individual. Several disadvantages of subject isolation were identified: elicitation of strong emotional behavior; legal barriers to its use; the subject may be too large or too aggressive to be physically placed in TO; isolation can function as a reinforcer rather than a punisher (Mansdorf, p. 391). Removing reinforcers from the environment where noncompliance occurred effectively reduced the frequency of noncompliance (Mansdorf, p. 392). Time out can also function as a negative reinforcer, i.e., removal from the environment increases the inappropriate behavior it follows (Plummer et al., 1977; Solnik et al., 1977). Several factors need to be taken into account: the nature of the time in environment, improverished v. enriched (Wahler, 1969); nature of the behaviors emitted during time out (Solnick, et al., 1977) and, expediency of administration, subject v. reinforcer isolation (Mansdorf, 1977). Scarboro et al. (1975) investigated the differences between within-room to and out-of-room TO on the reduction of oppositional behavior: "...both out-of-room and within room TO reduced oppositional behavior and increased compliance. The two time out procedures were equally effective in changing the two target behaviors; however, the within-room approach required significantly more administrations of time out than the out-of-room technique" (Scarboro et al., p. 252). These results may be due to the fact that other reinforcers, e.g., toys, were present during within-room time out; only the mother's attention was removed. Hobbs et al., (1978) compared time outs of differing durations (10 secs., 1 min., 4 min.). "In comparison to the control group all time out durations suppressed noncompliance and maintained lower levels during reversal" (Hobbs et al., p. 652). However, "longer durations appears to produce greater response suppression and more effectively maintain suppression when time out contingencies are removed" (Hobbs et al., 655).

Ramp et al. (1971) investigated the effects of a delayed TO procedure on the disruptive behavior of a nine-year old child. Each time the student was out-of-seat or talking without permission a light on his desk was illuminated. The child was told that each time the light went on he would lose five minutes of gym or recess which had to be spent in the TO booth. The light was a discriminative stimulus for punishment which would occur some time later in the day. The implementation of this procedure eliminated the disruptive behavior of the child.

MacDonough and Forehand (1973) outline some parameters of time out which investigators and behavior modifiers need to be concerned about: use of a verbalized reason for time out; issuance of a warning; the administration of time out, instructional v. physical; the location of time out, isolated v. nonisolated; the duration of time out; signaled v. nonsignaled onset and offset of time out period; the schedule of time out, contingent v. noncontingent.

Differential Reinforcement of Other Behavior (DRO)

DRO refers to "a procedure in which the occurrence of a particular class of behavior postpones delivery of reinforcement. Thus, the individual receives scheduled reinforcement except when engaging in the specified behavior" (Sulzer-Azaroff et al., p. 515). For every five minutes that Suzie is not crying her mother gives her hug. Each time Johnny complies with a teacher request within 15 seconds without complaining he receives a token. These are examples of a DRO procedure at work. A definite advantage of the DRO procedure is that it focuses on positive behavior; it reinforces a child for appropriate behavior.

Hall et al. (1971) report several studies which demonstrate that systematic teacher attention can be used effectively to improve classroom behavior of students. The dependent variables were talking-out without teacher permission, arguing, noncompliance. The independent variables consisted of ignoring occurrences of the aforementioned behaviors and praising the occurrence of appropriate classroom behaviors. Various backup reinforcers, such a candy or access to games, were also utilized.

The use of a DRO procedure requires that reinforcement be scheduled initially at very short intervals. Otherwise, the target behavior might occur and consequently be reinforced. Also, if the behavior occurs frequently, the subject might never experience the reinforcing event if the time between observations is too long. Finally, DRO like overcorrection, requires constant monitoring if it's reductive effects are to be realized.

Token Economies

A token economy is defined as "a contingency package." Tokens (exchangeable reinforcers) are given as soon as possible following the emission of a target response. The tokens are later exchangeable for a reinforcing object or event" (Sulzer-Azaroff et al., p. 524). A token economy can be used to increase appropriate behaviors as well as decrease inappropriate responses. Such a system can be used effectively in the home as well as at school. However, the "rules" for receipt of tokens and/or removal of tokens need to be stipulated before the economy is introduced.

For example, a token economy was instituted for a mildly retarded young man with cerebral palsy. He received tokens for using his language board, indicating toileting needs, and compliance during the activity at hand. Table 4 illustrates his "token card." People who interacted with him were required to punch a hole in the card each time he behaved appropriately. If he refused to communicate, had an accident, or ignored a request, tokens were taken away by circling the punched hole with a marker. At the end of each week, earned tokens were exchangeable for a chosen object or event. This system proved effective in modifying the young man's oppositional behavior. Smith and Sanders (1968) report equivalent success in the modification of extreme as well as minor behavior problems by using a token economy. As with the DRO procedure, effectiveness depends on the emphasis regarding appropriate behavior rather than attention to inappropriate responses, and consistent application. Also, one must be cognizant of the time factor. A report card for example, is a token reinforcer. However, it does not follow the parameters of successful modification. That is, a report car is not immediate, it is usually not relevant, nor is it applied consistently. Token economics have been frequently employed to modify appropriate classroom behavior (Axelrod, 1982).

CLIENT: ______________________________

DATE: ______________________________

Use of Language Board	○ ○ ● ○ ● ○
Toileting	○ ○ ○ ○
Compliance	● ○ ● ● ○

TABLE 5: Token economy card.

Combination Approaches

Most studies which report effective results utilize a combination of reinforcement for appropriate behavior and extinction or punishment for inappropriate behavior (Sailor et al., 1965; Wahler, 1969; Nordquist, 1971; Miller et al., 1972; Forehand et al., 1976; Wahler and Fox, 1980). For example, Wahler (1968) failed to obtain changes through the use of contingency shifting alone, i.e., praise for cooperative behavior, ignore oppositional behavior. However, when differential attention plus time out were utilized, oppositional behavior decreased. Treatment consisted of a time out period administered immediately upon the occurrence of oppositional behavior for five minutes unless a temper tantrum occurred (if this happened then the child remained in isolation until these behaviors terminated). Any cooperative behavior was immediately followed by parental approval. These procedures together produced a dramatic change in oppositional behavior. Also, the parents' reinforcing value increased as a function of the intervention.

Miller et al. (1972) report that a four-component procedure was most effective in producing a decrement in noncompliance of four year olds. The four components consisted of: (1) reissuance of instructions, (2) physical prompting, (3) 60-second time out without getting off chair or tantrumming, (4) teacher attention for compliance. The target behaviors were noncompliance to instructions, noncompliance to classroom routine, and disruptive noncompliance. When teacher attention for compliance alone was utilized, noncompliance behaviors gradually increased to above base line levels. A three-component package (without the time out component) proved to be functionally similar to the four-component procedure. A third condition, utilized reissuance of instructions and teacher attention for compliance, resulted initially in an increase of noncompliance behaviors, but these were gradually brought to under 10% (Miller et al., p. 7). These authors caution that it is not known whether the two component or three-component package could have been sufficient for the initial decrease in noncompliant behavior as these packages were investigated after the implementation of the four-component package in a reversal design (Miller et al., p. 9).

Zeilberger et al. (1968) report decreases in the screaming, fighting, disobeying, and bossing behaviors of a four-year-old with the mother as therapist. The intervention consisted of a two-minute time out contingent upon emission of the aforementioned responses and verbal praise every five minutes contingent on appropriate behavior. Forehand et al. (1976) investigated the effects of isolation, ignoring, negative attention and each of these presented in a random order, on the noncompliance of 32 subjects aged 4 - 6.6 years with the mothers as modifiers. All four procedures were effective in reducing noncompliance. During recovery sessions, all treatment groups say an increase in noncompliance except the group receiving all treatment groups say an increase in noncompliance except the group receiving all procedures in a random order. Thus, the varied use of discipline procedures maintained noncompliance at treatment levels after the procedures had been withdrawn (Forehand et al., p. 119).

Nordquist (1971) used a reversal design to evaluate changes in a 5.5 year-old referred for enuresis and temper tantrums. The latter consisted of screaming, kicking, throwing objects, hitting parents, and usually occurred when the parent(s) attempted to enforce an instruction. Treatment involved praise and attention for cooperative behavior and a ten-minute time out period for oppositional behavior. Enuretic activity was ignored. Results indicated that oppositional behavior varied with the systematic presentation and withdrawal of parental reinforcement contingencies. Enuretic activity correlated with the occurrence of oppositional behavior. Suppression of oppositional behaviors and enuresis persisted over 18 months. It was noted that the parental contingencies may have led to an increase in the social reward value of the parents (Nordqist, p. 246). These results are consistent with those of Wahler (1969). From two case studies dealing with oppositional behavior Wahler concluded that parental use of time out in conjunction with differential attention produced dramatic and stable changes in oppositional behavior (Wahler, p. 168). Furthermore, parental social reward value increased as a function of the program. Wahler states that low frequencies of cooperative behavior often results from the fact that the parents are poor sources of reinforcement. "It may be that changes in the children's behavior through time out led to changes in the parent's behavior, changes that were quite reinforcing to the children" (Wahler, p. 170).

Haswell et al. (1982) postulate that oppositional behavior of children ages 18 months to 6 years plays an important role in cognitive and emotional development. "Optimal development in this stage may be defined as the child's achievement of a healthy balance between independence and dependence through the provision of structure and opportunities for autonomous action" (Haswell et al., p. 14). Based on their study of oppositional behavior Haswell et al. (1982) make the following suggestions for the management of such behavior: 1) Be flexible when making transitions. Be aware of the child's ease in changing activities or speed in warming up to new tasks. Gradually shift attention away from an ongoing activity to the new activity. 2) Give verbal alerts about transitions. For example, a parent might say to the child, "In ten minutes, I will need you to help me set the table." 3) Offer choices. For example, "children might choose between a nap and a quiet reading time" (Haswell et al., p. 16) Allow the child time to comply. The greatest amount of non-compliance occurs within seconds of the command, but deadlines with time. Also, as the number of commands increases, occurrence of oppositional behavior increases. 5) Act positively. Positive action (smiling) accompanying a verbal suggestion (rather than command) facilitates compliance. In addition, compliance needs to be reinforced. Lytton (1975) noted that in over 50% of disciplinary encounters between parents and children, the children were given no reinforcement for compliance. 6) Use a time out procedure.

Hilton (1982) identifies various interventions to be used for noncompliance controlled by differing environmental events. If more than 25% of a child's interactions relate to negative behavior, then the child may be seeking attention through oppositional behavior. In such cases, use of DRO and/or TO is recommended (Hilton, p. 9). If the oppositional behavior appears to be maintained by escape or avoidance of the task at hand, the practitioner is faced with several alternatives. The schedule of reinforcement may not be short enough; steps toward completion of the task might be too difficult and/or too much. The teacher might also provide the child with acceptable means of not complying, i.e., teach more appropriate ways of communicating. Finally, no matter what the child does or says, the child should be required to complete the task even if the adult must physically prompt the child through the activity (Hilton, p. 12). Thus, the child is not allowed to escape or avoid the situation. If the oppositional behavior is the result of boredom, increased difficulty, program revision, response cost and more potent reinforcers might be utilized (Hilton, p. 13).

Monitoring

Monitoring procedures serve a dual purpose: they provide the practitioner with a means of determining the effectiveness of an intervention and a vehicle for providing feedback to the trainer. (The individual supplying reinforcers also needs a pat on the back!)

Reliability Probes

A reliability probe can be used to determine the accuracy of program implementation as well as accuracy of data collection. An independent observer could use the same measurement device as the teacher/parent during an intervention period. This would provide all concerned with data which reflects the degree of agreement with regard to occurrences of the target response. In this way communication is enhanced. It also allows the practitioner to observe program implementation firsthand so as to provide the trainer with feedback concerning documentation, consequation, etc.

Behavior Checklist

A behavior checklist is helpful in the identification of a problem. It also gives one an estimate of the frequency of occurrence of a target response. As such, it can aid in determining the effectiveness of the intervention. Data from checklists used before intervention can be compared with that collected during intervention. Behavior checklists used before and during an intervention can also be utilized afterwards, say once a month, by a teacher or independent observer to determine whether or not gains made during intervention are maintained with no systematic program in place.

Program Designs

In behavioral research, the design of a program is essential for verification of effectiveness. The three designs outlined below represent a small sample of available alternatives.

A reversal design is probably the easiest to implement. In a reversal design an intervention is implemented, withdrawn, and implemented. If the procedure is an effective one, a positive correlation between behavior change and systematic procedural changes should be evident. Use of a reversal design may be constrained by ethical considerations. It may not be in the best interests of the client or others involved to allow the behavior to return to baseline levels.

Another type of design is the multiple baseline across behaviors. This design allows the practitioner to determine the effectiveness of an intervention without reversal to baseline or pre-treatment conditions. A multiple baseline across behaviors is used when there has been more than one response targeted for change. For example, Tom frequently cries in class, throws materials, and shouts at the teacher. The teacher is asked to keep a frequency count of each behavior during 1/2 hour everyday for one week. At the beginning of the second week, the teacher is asked to record data again, but also to place Tom in time out each time he throws things. By the end of the second week, Tom is no longer throwing things, but is still crying and shouting at the teacher. The intervention is then systematically applied to the other target responses one at a time. This design allows a practitioner to say that the intervention caused the change rather than some other, extraneous environmental event.

A multiple baseline across settings is a similar design used for a single behavior occurring in a variety of settings or situations. The target response is measured in several settings. The intervention is systematically applied across settings rather than across behaviors. It also provides verification of intervention effectiveness.

Training the Trainers

Appropriate training of individuals responsible for implementing an intervention is integral for the occurrence of successful behavior change. It is important that trainers receive not only written instructions, but also demonstrations and "hands-on" opportunities. Evans and Evans (1983) found that the implementation of home-based behavior management programs was greatly facilitated by the addition of systematic demonstration to parent training. "Demonstration of the technique in conjunction with dissemination of information promotes a more exact implementation of the behavior change technique and increases the liklihood of success" (Evans and Evans, p. 40). After demonstration, role playing situations allow teachers and/or parents to "try on" a new way of responding towards a child. It gives them time to practice. It is during demonstration sessions and role-playing activities that the practitioner has the opportunity to practice what has been preached: praising appropriate responses and redirecting inappropriate ones. Indeed, throughout the duration of a program it is important to frequently reinforce accurate implementation. Hopefully, the practitioner will be reinforced by "thank you" or less frequent frowns by the trainer when talking about the program or child in questions!

Conclusions

Oppositional behavior(s) and effective reductive procedures have been discussed. It must be emphasized that effectiveness depends on accurate communication and consistency. Children, as well as adults, need to know what is expected of them and what consequences accrue to appropriate and inappropriate behavior. In addition, consequences need to be applied consistently. Otherwise, Johnny learns that "I can get away with it 50% of the time," for example.

Behavior does not occur in a vacuum: if one response is eliminated or reduced to near zero, something will take its place. For this reason, it is necessary to provide opportunities for success by behaving appropriately. There needs to be a positive component in the program. At times, this may need to be made more systematic. All too often children who engage in oppositional behavior are perceived by others in a negative way. Consequently, they are treated negatively. This only serves to worsen the problem as the very behavior considered inappropriate by the child is modelled for the child by significant others in the child's environment. Think of yourself as a mirror: if you have a frown on your face, you are likely to see a frown on the child's face. If you are smiling, the warmth will probably be reflected back to you.

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Vandalism and Property Destruction

School Psychological Services to Meet the Challenge

Stewart Ehly

Abstract: Vandalism and property destruction by children and adolescents have been a subject of concern to parents and educators in recent years. Concern has centered on the increasing costs of damage to school property and on methods of controlling future destruction. School psychologists are important agents in any school's efforts to confront the problems associated with vandalism. With contacts to the community, school district, and parents, the school psychologist represents a logical focus for the planning and coordination of change efforts with students and families. The chapter reviews conceptions of vandalism and property destruction to create a scenario of the current status of knowledge on dealing with the realities of destructive behavior. Traditional and recommended assessment practices are reviewed, then followed by an in-depth discussion of assumptions underlying intervention options. The chapter ends with a call for leadership by school psychologists in assuming change agent roles to assist children with problem behaviors.

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Introduction

As school psychologist to a large high school, you have been called to the principal's office and asked to work with the assistant principal and head counselor to "create a disciplinary policy that will force students to take responsibility for their actions." Reported acts of vandalism (ripped out locker doors, broken toilets, slashed bulletin boards, and damage to landscaping) have resulted in parental calls for tighter enforcement. As a psychologist, you strive to contribute your knowledge of adolescents, but realize the principal wants a strict and non-negotiable series of penalties for students caught destroying property. Your interest in structuring a long-term intervention to increase student interest in their school is "tabled for future study." Welcome to school psychology - 1986.

Schools in the United States have for the past 20 years attempted a variety of strategies to deal with vandalism on school property. Awareness of property destruction both on school campuses and in the community has lead to a variety of interventions by educators, mental health professionals, and juvenile justice institutions. Such interventions have met with varying degrees of success, but most Americans still believe that schools are places of questionable discipline and occasional incidents of violence. The school psychologist functioning in the role of consultant or intervention agent may be called upon to provide services centering around vandalism and property destruction. To prepare to meet the challenge of working with elementary and secondary aged students engaged in such actions, the school psychologist must be aware of past actions and current thinking that deals with acts of violence towards property.

Vandalism has been defined quite differently across the innumerable studies dealing with violence towards property. Panko (1979) arrived at a consensual definition from previous studies. He describes school vandalism as "unauthorized intentional damage and theft of school and district property, excluding theft for material gain of the actor and associated damages, if any" (p. 592). Zwier and Vaughan (1984) further specify that for an act to be considered vandalism it needs to be intentional or directed towards property with hostility. As Zwier and Vaughan state, "broken furniture and smashed windows do not ipso facto constitute acts of vandalism, and certainly not if they are due to thoughtlessness or carelessness."

The jargon associated with vandalism can become quite dense especially when educators and juvenile justice authorities apply their own labels to student behaviors. Two terms are important, however, to specify in this discussion of vandalism. Status offenders are children who commit offenses to laws that would not produce similar consequences for adults. For example, many states have laws defining school attendance, family responsibility for supervision of children and limitation on sexual behavior. The truant, runaway, or sexually precocious child may face consequences from juvenile authorities and be considered a status offender or child in need of supervision.

The juvenile delinquent commits offenses that involve consequences that would involve harsher punishment if the child had been an adult. Car theft, property destruction, and acts of violence to others may lead to commitment of the child to juvenile justice facilities. Delinquents may commit acts of vandalism, but not all acts of vandalism are considered the actions of delinquents. As noted above, vandalism refers to a narrow set of actions and may not lead to any other forms of nonsocial behaviors (i.e. delinquency). Status offender and delinquent labels imply that the child has been involved with the juvenile justice system, and may be formally adjudicated because of past behaviors.

The cost of destruction of property on school settings has increased over the years. Part of this increase reflects an increase in the cost of property rather than a necessary increase in actual incidence of vandalism. One recent report on acts of vandalism has argued that specific incidents of vandalistic actions have not increased significantly over that last 10 years. Rather, reporting of such acts has become more accurate (Nietzel, 1979). Regardless of the number of incidents, the costs associated with vandalism and property destruction have been staggering. Communities have reacted in a variety of ways to the expense of property destruction by implementing a number of strategies to control deviant behaviors. Interventions to cope with the actions of vandals have ranged from academic services that motivate students, to special educational programs designed for children with learning and behavioral needs, to school policy changes to control access to portions of school property. In the section titled interventions, a more descriptive elaboration of options will be presented for the reader.

While concern has increased in recent years over the acts of property destruction, there has been little awareness of the history in this country of students' reactions to the educational system. Newman (1980) argues that violence in schools can be traced back to the 1700s to show that American educational systems have not suddenly developed problems. Newman states that past efforts to control acts of property destruction and violence in schools were often quite severe, emphasizing corporal punishment. Little impact from such punishment can be established at least in terms of control of children and youth. While concern for children's behavior towards property may be somewhat distorted in the perception of the public, there are a number of sound investigations that have established specific correlates of vandalistic actions.

Sabatino et al (1978) state that their evidence suggests that norm-violating adolescent behavior occurs everywhere in the United States. "The external factors, i.e., geographic, socioeconomic, community characteristics are not stable predictors of school directed vandalism or violence, suggesting that perhaps internal (to the school) factors may be the decisive parameters (contributing to the identifiable motivators of school related crime." The authors argue that for adolescents a number of factors appear to motivate youth to participate in destructive behavior. Motivators include financial or property gain, pursuit of social cause, nonmalicious play, unfulfilled or unmet emotional needs, poor school achievement, and, less frequently, gang affiliation. Other investigators have identified possible consequences of involvement in vandalistic actions. Mitchell and Rosa (1981) sampled a group of children on a longitudinal basis. The authors report that "actions of the adolescent and adult that can be labeled criminal were often preceded by acts of stealing and destructiveness. The actions of children in destroying property may be a precursor of later criminality."

Another study by the Center for Juvenile Delinquency Prevention (1979) identified a specific profile for the typical vandal, who differs dramatically from the juvenile delinquent. The Center reported that the average vandal is between 12 and 15 years old, is a white male, comes from a home with a high degree of parent-child conflict, comes from a family less transient than would occur for delinquent youth, commits acts of vandalism in a group, and accepts the value of the schools but is doing poorly in competing with peers for academic and leadership acclaim. The Center similarly reported on a variety of characteristics of schools that suffer high property damage or loss: 1) poor communication between faculty and administration; 2) teachers have an authoritarian attitude towards students and are occasionally hostile; 3) an impersonal atmosphere exists between teachers and students; 4) there are extreme examples of competitiveness for leadership status among students; 5) there is a low degree of student identification with teachers and their efforts; 6) there is an overemphasis on grades by students; 7) there is a lack of support from parents; 8) there is a high degree of residential concentration around the school; 9) there is the use of grades as a disciplinary tool; 10) there is high enrollment for the size of the school; 11) there is an inconsistent or lax enforcement of rules. While the characteristics of schools having problems may vary, as we shall see below in the intervention section, enough investigators have found similar problems in school suffering high degrees of property loss that many districts have adopted similar approaches to working with children. Generally the response of schools has been to make areas of property suffering loss or damage less vulnerable. Many schools, as a consequence of vandalistic actions, provide 24 hour supervision of school grounds and extensive security measures. Access to the school can be controlled. New schools are designed with prevention of vandalism in mind. Some schools, as reported in the media, have video security systems installed to monitor critical areas of the building. Some schools experiment with new forms of curriculum, to stress greater relevance of academic content. Administrative policy, organizational structure, and forms of student-parent and community involvement have been experimented with by a number of schools. Actions of such schools have many times resulted in short-term success.

Recognition of the family as an intervention target has spawned a number of home-directed programs. Kazalunas (1979) argues that the roots of violence in school go back to changes in the family structure from the 1950s to the 1980s. Briefly, conditions under which parents of children today are being raised are quite different from the conditions experienced by the parents as children. Changes in authority and structure of the family parallel changes in perceptions of authority as delivered by teachers. Kazalunas argues that counselors play an important role in dealing with families experiencing stress around authority issues. Counselors can help by providing personal and psychological training for students, joining forces with parents and teachers to provide a common structure, establishing frequent contact with parents, and being actively involved with the students, both on a counseling and on an academic advising level.

Other schools have adopted more punitive approaches to acts of vandalism and violence in schools. Faily and Roundtree (1979) describe cooperative agreements that schools have entered into with police to control campus security. The security is boosted through cooperative agreements both inside and outside of the schools and may involve consequences to children and youth engaging in destructive behaviors that extend beyond discipline by the school district. Juvenile justice agencies have a clear responsibility for providing consequences to students involved in actions violating the law, and have generated a number of possibilities for such involvement.

Discussions of intervention have generated ethical dilemmas for some educators. How severely, for example, should vandals be punished for their action? Should schools and juvenile authorities apply consequences (e.g., suspension from school and adjudication leading to placement in a juvenile facility)? What should be done when a child tells you that she has been involved in vandalizing school property with her friends? The role of the psychologist in developing or influencing interventions with students labeled vandals will be elaborated below. We shall see that ethical concerns underlie all options facing the school psychologist, even during the assessment phase.

In summary, vandalism and property destruction have increasingly come to the awareness not only of educators (who have experienced the consequences of such actions for years) but the broader public, who now perceive schools as violent environments. Rising to meet the challenge of vandalism in the schools have been a number of efforts. These efforts, while meeting with varying degrees of success, share in common the desire to remove acts of violence towards property from the schools. As we have seen, however, the problems of violence in schools has existed since the earliest days of education in America. What options remain for school districts in dealing with vandalism and property destruction? The school psychologist, in his or her role within a school district, may be called upon to intervene with children and youth who have exhibited destructive behaviors towards property. Within the traditional activities of the school psychologist are assessment to identify academic and social characteristics of children and remedial and psychoeducational interventions to deal with specific problem behaviors. The following two sections expand on activities associated with school psychological services in dealing with children and adolescents engaged in vandalism and destructive behaviors.

Assessment

> In serving elementary and junior high schools in a small urban community, you have noticed some consistency across children who commit acts of vandalism and get caught. Many of the children come from middle income homes although their parents are not wealthy. Parents express frustrations with their child's actions, but show little confidence in changing home life. Few of the children are openly belligerent towards authority, and progress no further in the juvenile justice system. You experience success in linking parent education, school services, and community resources when parents are open to your help. One of your frustrations is being asked by school and juvenile authorities to administer psychological batteries to children in the expectation that "testing will tell all".

Assessment of children and adolescents who have been destructive towards property whether in the school or the community has traditionally followed the pattern of "get caught, get tested". Schools and the juvenile justice system in a community share a common strategy of establishing responsibility for actions and then administering a battery of psychological and educational instruments. A review of available evidence on the use of traditional forms of assessment clearly indicates little usefulness in such data collection. Behavioral and ecological assessment alternatives are preferred approaches to establishing parameters of problem behaviors and documenting changes in behavior when they occur.

The literature in both education and juvenile justice, however, focuses on assessment to document the academic and behavioral status of students already accused or identified for their actions. The literature reports some past efforts to predict delinquency or destructive actions in the school or community. Jones and Blaney (1975) evaluated some of the more established instruments that tap destructive or non-normative behaviors. The MMPI and more recently the PIC have correlated on some portions of the tests with delinquent actions. Jones and Blaney discuss two additional instruments that have been evaluated as prediction devices of delinquency. Glueck's Social Prediction Scale (1956) and Kvaraceus' Delinquency Proneness Checklist and Rating Scale (1961) are two instruments that have been used with minimal success in assessing children's proneness towards delinquent actions.

More commonly, the literature on delinquent and status offender children and youth is centered around performances of children on intelligence and achievement devices. Jones and Blaney (1975), with a sample of delinquent youth, found that many such youth function in the borderline retarded range of intelligence. They also found a disproportinate number of such children who had medical problems, involving epileptic seizures and other ailments. Several authors have noted difficulties in the performance of delinquent and status offender youth on traditional measures of reading and math. Indeed, most authors who have closely studied assessment scores on children involved in vandalism and property destruction have noted that such children and youth were experiencing problems with the academic curriculum. Some schools have seized on notions of improving curriculum, to the exclusion of other interventions with youth causing property destruction. McDermott (1983), unfortunately for such attempts, has argued that interventions that are solely school-based do not lead to significant lower levels of crime. Instead, what occurs is that the focus of violence shifts from the inside of the school to the outside, from the school grounds to the general community. Actually affecting the general level of property destruction and vandalism would involve coordination of efforts of community agencies and school officials.

As noted previously, the juvenile justice system has assumed responsibility for the majority of programs that deal with delinquent and status offense behaviors which reach their attention. Almost an identical array of assessment devices (formal in nature) is used in both juvenile justice and educational systems. Heavy reliance is placed on achievement test scores and IQs. Juvenile justice agencies have flirted more extensively with personality testing than have school districts, but with no significant expansion of information on children. Psychologists working within the juvenile justice system have done an excellent job of documenting the efficacy of interventions with such children and youth, and in some communities allow exchange of information on children between juvenile justice systems and the schools. Clearly, when children make transitions from the schools to segments of the juvenile justice programs, transmission of assessment data is a clear priority.

Weis (1983) surveyed the assessment literature associated with delinquency. Weis argues that assessment of children and youth has not greatly expanded our ability to work with these students. In contrast, Weis proposed that we devote our energies towards the assessment of specific interventions with populations considered high risk. (See division below on ecological assessment). He supports programs that collaborate energies of community and school services.

One final source of involvement of the juvenile justice system centers around children who emerge in the system because of abuse, abandonment, or assaults. An unfortunate pattern has emerged from some studies of children who are neglected and abandoned. According to one author (Carmen, 1983), 35% of children first seen as abused and abandoned or neglected eventually return to the juvenile justice system as delinquent teenagers. Carmen reports that nearly 80% of young girls institutionalized at one juvenile justice center were sexually or physically abused by parents. Other authors have noted violence associated with alcohol or drug use by parents, siblings, or children may result in behaviors that are noticeable to the juvenile justice authorities. Sources of pressure on children can be documented as a precursor to planning for change.

What then are the alternatives for assessment by school psychologists? As noted already, traditional batteries of psychological and educational data can be collected or may already be available on children involved in vandalism or property destruction. There may be little that the school psychologist can do with the individual child to predict actions, but there is a clear path for the professional to pursue in documenting characteristics of children who do violate the law. Adequate documenting of correlates of vandalism and property destruction makes sense at a local level, instead of seeking out national or state statistics. Emphasis on modifying the specific actions of children experiencing difficulty, whether through behavior modification or management, implies an extensive degree of data collection on base line and subsequent behaviors. The intervention section will explore some of these options but at this point the psychologist must consider specifically which data will be of most use in planning for intervention.

Behavioral and ecological assessment approaches are a preferred alternative to traditional efforts when the psychologist's goal is to document antecedents of children's actions and to generate information to shape interventions. By specifying problems of a child, behavioral assessment, in conjunction with consultation, establishes a base line for change efforts and serves as a springboard for intervention. Kanfer and Phillips (1970) propose seven components to the assessment of behavior, all elements of which can be applied to work with children involved in vandalism:

1) Initial analysis—specifying behaviors of the child as a basis for analysis of the problem situation;

2) Problem situation classification—specifying environmental variables to clarify the problem situation. Some variables could include antecedents of the problem. Circumstances at home and past exchanges between the student and school officials could help clarify your perception of current circumstances;

3) Motivational analysis—identifying what will reinforce and punish the student, an especially important component of intervention planning;

4) Developmental analysis—identifying biological, behavioral, and sociological changes in the student that could affect interventions—changes in home life are often critical data in shaping interventions. Which parent will support you can be established and built into plans;

5) Self-control analysis—identifying behaviors and situations that the child can control. The child with limited self-control may require training in a cognitive behavior modification program, for example, before an academic and behavioral contract with the school can produce success;

6) Social situations analysis—specifying the relations of the student with peers and adults to identify aversive and reinforcing qualities of exchanges. By identifying adults and peers who can reinforce appropriate behavior, the school psychologist can master an important component of many intervention programs;

7) Socio-cultural physical environment analysis—evaluation of standards of behavior expected of the student and that student's opportunities for support in achieving such standards. Identifying surface and hidden agenda of school staff can contribute to developing an intervention plan that incorporates expectations of the school staff, parents, and the student.

Behavioral assessment can include observing the child under structured and unstructured circumstances, and then analyzing the behavior content of observations. Using behavioral assessment, the psychologist can specify the nature, frequency, and duration of problem behaviors, including vandalism. By studying reinforcers in the child's past, intervention plans can build an established reward system to produce change (even using the Premack principle).

Ecological or environmental assessment builds on behavioral assessment techniques to study systems surrounding the child (school, peers, family, community). The psychologist can document teacher-student and student-student exchanges using any of a number of existing measures (Flanders, 1966; Goodwin & Coates, 1977; Brophy & Good, 1974). Sociometric analysis can provide understanding of a child's educational experiences, potentially identifying problems in peer status and serving as a stimulus toward social skills interventions. Classrooms as learning environments can be assessed informally, with the psychologist establishing the student's perceptions of curriculum, learning experiences, teachers, peers, and so on. The child's attitudes towards school and learning may be the clearest signal that an intervention to enhance the quality of the learning experience is needed.

Analysis of peer involvement outside of school can be especially fruitful, given that most acts of vandalism are conducted with one or more peers. Establishing who spends free time with the student, what goes on during that time, what activities the child forsakes (homework, family activities) to be with peers, and circumstances under which the child destroys property (where, when, how, etc.) provides important data before proceeding farther in planning for change with the student and family. Assessment of the family life is a logical next step. What is home life like, what support does the child perceive from parents, what control do the parents perceive having over the child, and to what degree do the parents reinforce school expectations are only a few of the questions that can be pursued by the psychologist. While some assessment devices do exist to focus on family life (see especially McCubbin & Patterson, 1981, for tools centering on family stress and coping) questions generated by the psychologists to match the specifics of each case will allow closer attention to individual circumstances.

Behavioral and ecological assessment are unfamiliar to many educators and juvenile justice workers. The psychologist may be required to administer traditional psychological batteries even when preferring more behavioral approaches. Resolving the conflict between school and professional standards is seldom easy. Many psychologists churn out the required paper work and use behavioral or ecological assessment for developing interventions. In some districts, psychological batteries are needed only if the child is to be processed into a special education program. Each professional must decide the extent to which he or she compromises judgment on best practice to meet external expectations.

Personality measures have resurfaced as recommended sources of information to better understand correlates of problem behavior. While psychologists may be uncomfortable administering the MMPI or the Rorschach, the Personality Inventory for Children is a recent addition to psychological assessment that allows for an exploration of children's behavior. The instrument is administered to the biological mother whenever possible and documents that person's perceptions of an array of behaviors exhibited by the child at home, and school, and in the broader community. A rich body of research has emerged on the performance of delinquent and status offender children and youth on portions of this instrument. In addition to the PIC, data from other personality or self-concept devices can be acquired to expand understanding of the child's perceptions of the environment.. Personality measures can serve to corroborate data from other sources or lead to hypotheses stimulating additional assessment.

Keeping track of the child's progress through portions of the curriculum via teacher-made tests may allow the school psychologist to observe specific academic weaknesses of the child. Subsequent involvement with the child and teacher can focus on remediating skills that are readily identifiable on these teacher-made instruments. Increasing student competency academically is an established route towards motivating children to maintain their school involvement.

Accuracy in all data collection for planning purposes cannot be under-emphasized. School psychologists can heed the lessons of the behavior modification literature in applying reliable and valid information in working with children engaged in vandalism and property destruction. Cullinan (1975) provides an excellent example of the application of behavior modification with disruptive, delinquent, and deviant adolescents. The author describes antecedents of delinquent actions in behavioral terms and builds behavior modification programs to eliminate deviant behaviors. The article is a recommended one for teachers who would be interested in better understanding how behavioral management programs can be applied with delinquent and status offender youth.

A final important function of assessment is to evaluate outcomes of involvement with children and youth. Individual therapies or small group programs with target youth may be based on Adlerian, behavioral, or milieu oriented approaches but all share the characteristics of requiring process and product documentation. The school psychologist must collaborate with concerned professionals both in the school and the community in generating and storing assessment information. If the goal of assessment is to be the collection of information for instructional purposes, then only one outcome—that of instruction—appears justified. When the scope of assessment, however, is widened to include the community, assessment can gather information to assist the youth to cope more effectively within the limits of any system.

Intervention

> John, a white 12 year old, recently entered junior high to terrible reviews. He never seemed to be where he was supposed to be, and soon became a common visitor to the vice principal. When he began to leave school without notice, his parents were called to have a conference with the school psychologist, assigned to deal with all truants and school leavers. Both parents canceled all meetings with varying excuses and never did appear at school. In November, a silent alarm at school alerted police, who apprehended John in a science lab. He had sprayed chemicals around the room and overturned desks. He confessed several other acts of school vandalism to juvenile authorities. With the agreement of school and juvenile authorities, John's case was deferred on the understanding that he would participate in counseling with the school psychologist while his parents met with a community group offering a "parent rap group" for families of delinquent and status offenders.

While assessment can play an important role in documenting what has already been established (that is, correlates of acts of school violence and vandalism), many interventions spring from the act of vandalism or property destruction itself. No assessment need apply. Goldstein, Apter, and Hartoonian (1983) have summarized the variety of solutions that have been attempted for school violence and vandalism. Surveying this list, the reader will notice that few if any of the solutions imply collection of assessment information before the intervention was attempted. The reader is encouraged to review the table, be appropriately staggered by past efforts, and select those strategies which evolve from a preferred focus of intervention (e.g., student, teacher).

Table 1

Attempted Solutions to School Violence and Vandalism

I. Student oriented
Diagnostic learning centers
Regional occupational centers
Part-time programs
Academic-support services
Group counseling
Student advisory committee
Student patrols (interracial)
Behavior modification: contingency management
Behavior modification: time out
Behavior modification: response cost
Behavior modification: contracting
Financial accountability
School transfer
Interpersonal skill training
Problem-solving training
Moral education
Value clarification
Individual counseling
More achieveable reward criteria
Identification cards

Table I (con't.)

I. Student oriented
Peer counseling
Participation in grievance resolution
Security advisory council
School-safety committee
I. Teacher oriented
Aggression-management training for teachers
Increased teacher-student nonclass contact
Teacher-student-administration group discussions
Low teacher-pupil ratio
Firm, fair, consistent teacher discipline
Self-defense training
Carrying of weapons by teachers
Legalization of teacher use of force
Compensation for aggression-related expenses
Individualized teaching strategies
Enhanced teacher knowledge of student ethnic milieu
Increased teacher-parent interaction
III. Curriculum
Art and music courses
Law courses

Table I (con't.)

III. Curriculum

Police courses

Courses dealing with practical aspects of adult life

Prescriptively tailored course sequence

Work-study programs

Equivalency diplomas

Schools without walls

Schools within schools

Learning centers (magnet schools, educational parks)

Continuation centers (street academies, evening high schools)

Minischools

Self-paced instruction

Idiographic grading

IV. Administrative

Use of skilled conflict negotiators

Twenty-four custodial service

Clear lines of responsibility and authority among administrators

School-safety committee

School administration-police coordination

Legal-rights handbook

School-procedures manual

Table 1 (con't.)

IV. Administrative
Written codes of rights and responsibilities
Aggression-management training for administrators
Democratized school governance
Human-relations courses
Effective intelligence network
Principal visibility and availability
Relaxation of arbitrary rules (re smoking, dressing, absences, etc.)

V. Physical school alterations
Extensive lighting program
Blackout of all lighting
Reduction of school size
Reduction of class size
Close off isolated areas
Increase staff supervision
Implement rapid repair of vandalism targets
Electronic monitoring for weapons detection
Safety corridors (school to street)
Removal of tempting vandalism targets
Recess fixtures where possible
Install graffiti boards

Table 1 (con't.)

V. Physical school alterations
Encourage student-drawn murals
Paint lockers bright colors
Use ceramic-type, hard-surface paints
Sponsor clean-up, pick-up, fix-up days
Pave or asphalt graveled parking areas
Use plexiglass windows
Install decorative grillwork over windows
Mark all school property for identification
Use intruder detectors (microwave, ultrasonic, infrared, audio, video, mechanical)
Employ personal alarm systems
Alter isolated areas to attract people traffic

VI. Parent oriented
Telephone campaigns to encourage PTA attendance
Antitruancy committee (parent, counselor, student)
Parenting-skills training
Parents as guest speakers
Parents as apprenticeship resources
Parent as work-study contacts
Increased parent legal responsibility for their children's behavior
Family education centers

Table 1 (con't.)

VII. Security personnel

Policy K-9 patrol units

Police helicopter surveillance

Use of security personnel for patrol

Use of security personnel for crowd control

Use of security personnel for intelligence gathering

Use of security personnel for record keeping

Use of security personnel for teaching (e.g., law)

Use of security personnel for counseling

Use of security personnel for home visits

Development of school security manuals

VIII. Community oriented

Helping-hand programs

Restitution programs

Adopt-a-school programs

Vandalism-prevention education

Mass-media publication of cost of vandalism

Open school to community use after hours

Improved school-juvenile court liaison

Family back-to-school week

Neighborhood Day

Table 1 (con't.)

VIII. Community oriented

Vandalism watch on or near school grounds via mobile homes

Encourage reporting by CB users of observed vandalism

Community-education programs

More and better programs for disruptive/disturbed youngsters

IX. State and federal oriented

Establish uniform violence and vandalism reporting system

Establish state antiviolence advisory committee

Stronger gun-control legislation

Enhanced national moral leadership

Better coordination of relevant federal, state, community agencies

Stronger antitrespass legislation

More prosocial television programs

Less restrictive child-labor laws

The actions of schools and communities have been extensive and, as noted earlier, have experienced a range of success. Literally hundreds of studies can be cited that deal with variations of each of these solutions. A recent study, however, has challenged some of the conclusions that studies have reached regarding the impact of interventions. Whether or not the interventions involve the school, family, or community, an important dimension to consider in evaluating an intervention is the ideology of the system or community within which the vandalism occurs. Zwier and Vaughan (1984) propose that ideological orientation involves a number of assumptions about the sources of vandalism and the actions that would then work. Table 2 presents their depiction of the relationship between ideological orientation, assumptions concerning the cause of school vandalism, and the types of solutions offered.

Table 2 follows

Table 2

The Relationship Between Ideological Orientation, Assumption Concerning the Cause of School Vandalism, and Type of Solution Offered

	Type of solution		
	Specific	Diffuse	
Ideological orientation and assumption of cause	Physical environment	School System	Community at large
Conservative Vandals are deviant They must be caught and punished.	protection of school and school grounds, employment of security officers and caretakers[a] (superficial)	encouragement and enforcement of school rules, use contingency contracts	involvement of community in antivandalism patrols and (parent) restitution programs, dependence on judicial system
Liberal The school system is malfunctioning. Vandals capitalize on this.	improvement of the design, appearance, and layout of the school and school grounds	modifications in school climate, curriculum, and use of special conflict management programs[a]	extension of recreational activities, use of school after hours for health and social services
Radical The school system is debilitating. Vandalism is a response of normal individuals to abnormal conditions.	promotion of radical changes in the structure and appearance of the school, approval of policy to decrease the size of large schools and maintain small schools	provision of student involvement in decision-making processes, adoption of changes in assessment procedures, and exploration of alternative schooling methods	involvement of the whole community in school affairs, installment of community education programs, improvement of social situation in society at large[a]

[a] The solution considered most favorably by the particular ideological orientation.

Zwier and Vaughan argue we must consider reevaluating our previous knowledge about interventions in the light of ideological orientations and pursue research in the future incorporating this dimension. The authors conclude their article by stressing action research (a strategy school psychologists could consider implementing). The central point of their article is of greater interest here: that is, causes and assumptions about causes of vandalism play an important role in dictating strategies that are selected by school psychologists.

The Conservative Orientation

Zwier and Vaughan (1984) describe the conservative orientation as based on the attitude that children who commit acts of vandalism must be deviant by their actions. Any act of vandalism should be punished and the environment of the school must be protected. Schools with a conservative orientation (representing more than half the literature on vandalism) have detailed strategies to vandal-proof the school environment (Irwin, 1978). Electonic gadgets play a central role detecting the actions of deviant children and youth. While sophisticated electronic devices may be effective, they do entail a cost that can be equivalent to the actions of the children themselves. Zwier and Vaughan note that the outcomes of these projects do not necessarily bear on the effectiveness of the various strategies because of problems inherent to the designs of research done on such programs.

Schools with conservative orientations may focus on student involvement programs, in some cases adopting a behavioral program that involves students in contingency contracts for property destruction. One school district reported by Zwier and Vaughan added money to a school fund for students as repairs for vandalism went down. Other forms of involvement with students have centered on treating the offender as the source of the problem. Psychological treatment with an individual or group is emphasized in a conservative orientation.

A final dimension of the conservative orientation involves the community. Vandal-watch programs may be developed around school areas. Parent restitution may be an option to compensate schools for losses by children. Regardless of the intervention pursued under this orientation, the student remains the focus of all intervention efforts and bears the consequences of his or her actions over the long-and short-term.

The Liberal Orientation

The liberal orientation assumes that students who engage in acts of vandalism do so because of problems within the school system. Actions under this orientation may resemble the conservative approach in that school environments may be modified to make them more attractive or durable. Decreasing the likelihood of vandalistic actions may involve modifying the physical environment to change access, lighting, or physical attractiveness. The age of the school building has been related to the number of incidents and costs of vandalism. Some authors have argued that the older the building the more likely it is to be vandalized. Other writers have not supported this finding. One recent study (Wells, 1975) found more vandalism in newer schools. Another author (deBuzna, 1975) said that appearance of the school was of more importance than age as a correlate of vandalism. The liberal orientation stresses that children who enjoy their environment and are proud of it are less likely to damage it.

Because of the focus in the liberal orientation, actions of children are not an emphasis as much as actions of the school staff in shaping interventions. Attitudes of principals are considered central by many authors in determining what property destruction occurs in a school area. Perceptions of teachers appear to be important in other studies. There is, however, no clear cut evidence of the relation between school climate and school vandalism. Zwier and Vaughan argue that the factor that could be most important in the frequency of vandalism is the consistency with which school policies and disciplinary rules are enforced. Consistency in action is a central theme in the liberal literature. Common to this orientation is an emphasis on increasing the interest and involvement of children, both with school staff and the community at large. Parental involvement is important under this orientation in terms of structuring attractive alternatives to negative school attitudes. One author (Gladstone, 1978) found that male students were more likely to become vandals when "a) there is lax parental control, b) the student is a low achiever, c) he dislikes school, and d) he spends much of his free time in the company of a street gang."

The Radical Orientation

Under the radical orientation, vandalism is perceived as a normal reaction to debilitating circumstances. Characteristics of the broader community and schools as they exist in the 1980s both structurally and interpersonally are seen as leading to vandalism and property destruction. Several authors have reported that larger schools experience more vandalism than smaller schools. This belief has lead to proposals that new schools be smaller in size and allow for greater student-staff identity. Increasing the personableness of schools would encourage feelings of belonging and lead to fewer acts of vandalism. The school system is seen under this orientation as responsible for academic failure and feelings of resentment that students may experience. The curriculum is a central focus of change efforts under this orientation.

The community at large shares an equivalent degree of responsibility for the conditions that exist in the school and broader community. Strategies that recognize this responsibility are seen as priorities. Programs for community education and parental involvement are stressed. For any of these community and school efforts to succeed, Zwier and Vaughan summarize previous findings that school officials must be motivated to involve the community and must not react simply because of directives from school boards. Similarly the community must want to be involved in school programs. Finally, for these programs to work the students and parents must perceive the actions of the school as working in their favor.

Coordination of Services

From Zwier and Vaughan's findings, failures of any intervention to deal with problems of school vandalism do not tell us much about the specific intervention. We must understand the assumptions that individuals make as they look at children engaged in destructive behaviors and choose alternatives to introduce change before we can clearly document the outcome of such programs. Being able to capture political realities, economic circumstances, ideological orientations, and psychological considerations at one time appears to be an awesome if not impossible task. The school psychologist remains perhaps the best single trained professional in any school system that has the resources to accomplish such a task. Recent writings on the power dynamics that exist within schools and community emphasize the reality that school psychologists cannot ignore broader and more tenuous dimensions of change processes in looking at what occurs in schools. Sarason (1982) has noted that assessing children and providing interventions is at best naive if the school professional does not recognize that change occurs very slowly in educational systems. If the focus of change is on the child and not on the broader system (both physical and adult), then the psychologist has achieved merely realization of the conservative orientation. Liberal and radical alternatives to change are available for any professional but entail a redefinition in many instances of the role of the school psychologist. That professional cannot stand alone in any of the three orientations towards change. Coordination of services must be accomplished at the child, family, educational and support services levels before any orientation can be effected.

Clearly, assumptions surrounding the causes of vandalism shape intervention priorities. One problem that was discussed under the assessment section is of relevance: school officials and the psychologist can differ in their interpretations of children's behavior and vary in proposals for change. Again, a psychologist can opt to work within the system using that body's tools for change or can strive to influence policy that deals with interventions for children. The individual psychologist seldom has the leverage to effect change when going against established policy. Departments responsible for the provision of psychological services can play an important role in working with school administrators to negotiate alternatives to rigid policies which treat all children as if they were stamped out of a machine. The individual psychologist is responsible for influencing actions of his/her department, potentially causing a spread-of-effect to an entire system.

Monitoring

Following the progress of change efforts and documenting intervention outcomes involve a school psychologist committed to the long-term monitoring of a child's program. When a child is caught committing property destruction on or off campus, information rapidly accumulates on that child's behavior. The vice principal, counselor, and school social worker may keep separate records of contacts with students and parents. Juvenile authorities in contact with the case generate piles of forms and notations. Seldom, however, does a person associated with the school assume responsibility for coordinating the flow of information on a child over time. What generally occurs is that some agent, school or juvenile authority applies an immediate consequence and everyone assumes all others are informed of all actions. Would that communication was so easy!

The school psychologist, with the flexibility to move quickly across community sites, is ideally suited to monitor information on cases involving students apprehended for vandalism. Monitoring can involve collecting data on the child's past involvement with school and juvenile authorities, synthesizing assessment information from available sources, coordinating interventions to student and parents, and documenting long-term outcomes of such treatment. However data are stored, they can be maintained in a form allowing research centered around groups of similar children and youth.

As a coordinator of monitoring efforts, the psychologist will maintain contact with juvenile case workers, when assigned. A not unusual experience will be seeing a child first encountered at an early age re-surface in junior high school having problems with authorities. Maintaining accurate records of children also will assist in cases before entering into discussion with parents about possible actions. One school psychologist with 12 years of experience in a district maintained a personal record of each case involving services outside of the school (e.g., juvenile justice, mental health services). Because some children who commit vandalism do graduate to more serious crimes, the psychologist's system helped him to work closely with juvenile officers to coordinate services. As with all liaison opportunities, past successes in joint problem-solving smoothed the way for quick action in new cases.

In sum, monitoring is a vital function in the intervention and post-intervention phases of assisting students and their parents. The school psychologist with expertise in communication can document outcomes and provide feedback as appropriate.

Conclusions and Considerations

The actions of children and youth in schools are the arena of school psychological services. Academically and behaviorally, students engage in behaviors daily that can bring them to the attention of school administrators and support staff, including the school psychologist. Actions labeled as vandalism or as property destruction in the broader community bring that student to the attention of other community agents, such as members of the juvenile justice system. A coordinated effort between school and community agencies is recommended by every orientation towards intervention with children engaged in destructive behaviors. Limitations on the actions of professionals must be understood within the context not only of what occurs in the school or even the broader community but within the confines of the political or ideological realities faced by school and community-based professionals. Understanding these realties is an initial task for the school psychologist. Translating realities into school psychological services is a big second step. Limitations on impact of these services coincide with limitations on understanding what is actually occurring with the child, his or her parents, and the staff with whom that student has contact.

The literature on vandalism and property destruction is an extensive one, offering many clues for assessment and intervention options. The following bibliography provides a sampling of the best of that literature. The school psychologist cannot, however, read this literature without recognizing that the school psychology profession is relatively unexposed to the realities of working with delinquent and status offender youths. Limited literature exists targeted at school psychologists dealing with the problems discussed in this chapter. The juvenile justice literature instead offers many suggestions for working (with some degree of success) with children. The reader may be uncomfortable with that success, recognizing that punitive actions fall almost entirely within the conservative orientation. Though the bulk of the literature has followed this orientation, the reader may be motivated to engage in alternative approaches to working with children and youth and documenting the impact of such efforts. School psychologists, because of the locus of their efforts, are in an ideal position to begin to document what actually is occurring with children who are engaged in vandalism or property destruction. Generating case histories for these children and youths and following their school and community contacts over the long-term will greatly expand the school psychological literature and enhance our understanding of service options.

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Headache--Considerations for the School Psychologist

Larry Gile

Abstract: Cause and categories of headaches are presented. Assessment, intervention and treatment approaches are reviewed. Consideration for collaborative medical consultation is discussed.

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Definition, Background and History

Headache is the United States' number one source of chronic pain, with over forty million sufferers (Diamond, 1983). It is also the most common ailment in the country, affecting some 90% of the population (Sci. Dig., 1983).

Therefore, it would be novel for a school psychologist to not encounter children who experienced some form of headache as a component of their diagnostic profile. This chapter is written to provide the school psychologist with information regarding the symptom of the "headache," and recommendations as to what actions the practitioner might consider with respect to this condition.

Since a comprehensive evaluation of a child entails the compiling of behavioral and health related information this should reveal to the school psychologist the existence of chronic or unusual headache symptoms if they are present.

Chronic or unusual headaches may be a signal of a serious physical condition. The discovery of headache symptomatology may be gleaned from a health history or in the course of interview with child or parent.

Even if no serious health problem is present, headaches usually have some negative impact on the child's behavior and should be considered in relation to the child's total status. Amelioration is required regardless of the headache symptoms' cause, be it environmental or behavioral factors (effect) or if the headache stem from an organic or physical phenomonen.

The 1930's, beginning with Wolf's research, marked the birth of the scientific study of the psychophysiological headache (Dalessio, 1972). Wolf showed headaches could result from pathophysiological reactions of vascular and musculoskeletal mechanisms without the presence of central nervous system disease. He stated that for some forms of headache, an inherited predisposition existed. Wolf also made clinical observations which suggested that chronic headache sufferers often exhibited pathological emotions and personality traits.

Within the last ten to fifteen years, considerable scientific inquiry has been focused on headaches by both the medical and psychological communities. Bakal (1981) succinctly traces the history of headache research up to 1980, summarizing the belief that muscle contraction and migraine headaches are distinct syndromes with district etiologies and separate treatment requirements. This is one of the few aspects of headaches seldom questioned by either physicians or psychologists.

Confusion exists concerning the professional sphere of responsibility of "the headache". Research on the topic by an Iowa network for Obtaining Resource Materials for Schools (INFORMS) reports numerous references from both the psychoINFO and the MEDLINE data bases. While some members of both professions may claim exclusivity over the symptom, the author proceeds under the concept of mutuality. Ideally, the school psychologist will consider and, where appropriate, involve the medical community when dealing with headache symptomatology. There could also be considerable advantage in having members of the medical community refer to school psychologists whose expertise could help effect relief or amelioration of headache. Certainly, the more knowledgeable school psychologists are with respect to the broad topic of headache, the better equipped they will be to understand the whole child.

The criteria for referral and involvement of a physician are not exact or universally accepted. Certainly appraising the parents or guardians of the symptoms and concerns is mandatory. However, because headaches can be a signal for numerous physical conditions requiring medical attention, over-referral may well be the wisest course.

There are conditions which would clearly necessitate medical involvement, possibly casting the psychologist into the role of advocate for a referral in the face of reluctant parents. According to Lawrence W. Geotz, M.D., a specialist in family practice, a child experiencing headaches on a daily basis should definitely be referred to a physician. Headaches occurring as frequently as three to four times per week would also be a noted concern by Dr. Geotz. Less frequent headaches, but accompanied by any visual disturbance or being located in the top of the head as opposed to the temperal or forehead regions, would also be in need of referral. (L.W. Goetz, personal communication, July 11, 1984).

Apart from the more clear cut alarm indications, perhaps the advice offered to the headache sufferer by neurologist Dr. David R. Coddon should be incorporated into the school psychologist's referral criteria (Coddon, 1982). Coddon advises consultation with a physician if the individual experiences a new, sharp pain in the head that is truly attention getting or if a headache lasts "too" long, or is unusually painful, or is accompanied by new, previously unexperienced symptoms.

There is a lack of concensus in the literature as to types of headaches on a classification schema and terminology. There does appear to be reasonable agreement defining the broad phenomonen of the headache. Although the term "headache" is a fairly nonspecific descriptor, it is commonly used to communicate the existence of the sensation of pain located internally within the cranial cavity. It is communicative, but non-specific in that further description is required to give more precise meaning to what the complainant is experiencing.

Expanding on definition, Bakal (1981) asserts that a headache is a psychological disorder where the illness results from complex interactions of psychological, environmental, physiological, genetic and biochemical variables.

Categorization of headaches can be puzzling. An assumption of the psychobiological model is that headaches result from a predisposition and occurs in the presence of stress-related events; however, the psychobiological predisposition may eventually operate independently from the psychosocial stressors (Bakal, 1981).

While there are numerous headache classification systems to be found among professionals working with the phenomonen, most divide headache into categories of 1) muscle contraction or tension headache, 2) vascular, which includes migraine and cluster headaches, and 3) organic, caused by brain lesions, weaknesses in blood vessels, head rauma, disease, or physical environmental factors such as toxins or pollutants (Diamond, 1983; Coddon, 1982; Mirkin, 1982; Sci. Dig., 1983).

Parameters of Symptom Elements

Mere knowledge that a client experiences headaches is unspecific. Further description is required in order to significantly contribute to the diagnostic profile or the client:

Intensity—How much discomfort does the headache engender? Pain is a distress signal, the measurement of which is random since pain is a subjectively determined event. It is probably sufficient for the school psychologist to have the client place intensity somewhere along a continuum of "annoyance" to "incapacity".

Frequency—How often does the client experience headache pain? As with most parameters of headache, there is no absolute, scientifically formulated gauge by which to judge frequency.

Location Within the Head—Where does the pain occur? Is it always the same location? Is it only one side of the head that is affected, in the back of the head, the temple area, forehead, behind an eye, generalized throughout the head, etc.

Duration—How long do the headaches last? Is there uniformity to them or are their durations variable?

Onset—When do the headaches occur? Does the client awaken with them? Do they develop during or following specific activities such as reading, physical exertion, meals or the eating of particular foods, do they develop at specific times of the day or week or before, during or after particular events?

Accompanying Sensations, Behavior or Physical Phenomonen—Are there sensory disturbances prior to onset or during the headache? Visual disturbances might take the form of spots before the eyes, distorted visual field (tunnel vision or reduced peripheral vision), and light flashes. Is the client more sensitive to light or sound? Is there tingling or numbness in a hand, foot or other part of the body? Does the client feel nauseous or vomit at any point? Is there increased drowsiness at any point? Does the client experience confusion, anxiety or giddiness prior to or during the headache episode?

Post Headache Factors—Does the client experience any of the effects listed above under "Accompanying Sensations, Behavior or Physical Phenomonen" following the subsiding of headache pain?

History—Is there a pattern to the headaches? How long has the client been experiencing them? Have they changed over time, in nature, in frequency, in intensity, or in any other way? What is the headache experience for close family members?

Categories of Headaches

No absolute agreement on the categorization of headaches exists. While Bakal (1981) notes a preponderance of agreement as to muscle contraction and migraine headaches being distinctly separate entities, he goes on to postulate his own view that there are similar psychobiological processes operating in both. The major process common to both is tonic muscle activity in the head and neck. He acknowledges a possible vascular component, manifested through increased peripheral resistance resulting from an increase in sympathetic muscle tone. But muscle contraction is the basic mechanism in both major categories.

Solely for the purpose of this chapter, broad categories of headache causation will be addressed: muscle contraction, vascular, organic, psychogenic pain disorder, and environmental, duplicative and miscellaneous categories of headache. Psychogenic headache and behavioral/psychological factors related to headache will be discussed.

Muscular Contraction or Tension Headaches (Also categorized as "stress" headaches)

Muscle contraction or tension headache is common among children (Rothner, 1979). Epidemiologic studies in England and Sweden have resulted in incident figures for children in the 12% to 15% range (Sparks, 1978).

Mirkin (1982), who identifies tension or stress headaches as being the most common, describes the phenomonen of neck and head muscles tightening and causing their blood vessels to constrict. The blood vessels then expand and the result is pain in the temples or back of the head. This explanation adds to the confusion between muscle contraction and vascular headaches found throughout the literature.

Walpin (1983) writes that 90% of headaches which motivate individuals to seek medical attention are "mechanical," or related to posture, movement or muscles. He cites such casual factors as the frequent cradling of a telephone between head and shoulder, tongue position—resting the tongue in the wrong place in the mouth which exerts enough force on the head to thrust it out of delicate position on the neck with resultant muscular repercussions that include headaches—and head tilt while reading.

Another explanation is that headaches are believed to usually result from psychological or physical stress which causes scalp or other muscles on the cranium to constrict too hard and/or too long with the result that nerve endings in these muscles are stimulated and relay an electrical impulse to the brain. The brain in turn interprets the signal as papin (Sci. Dig., 1983).

Most victims of tension headache are suffering from stress or depression: depression, according to Seymour Diamond (1983), is by far the most common element. Diamond notes that tension headaches are often accompanied by sleep disturbances.

While etiology for muscle contraction headaches is not agreed upon, numerous practitioners note the presence of mild to severe psychologic problems associated with this type of headache (Aquilina, 1982). Even though the presence of psychological problems in the form of school, social, or family related difficulties may be present, this form of headache is viewed as related, but distinct, from the "psychogenic" headache. The major physchological component of muscle contraction headache would seem to be stress rather than psychopathology. These headaches are directly related to excessive and sustained contraction of muscles in the scalp and/or neck (Cox, Freundlich & Meyer, 1975).

Descriptions by tension headache sufferers tend to place the pain "around" the head, or band-like, additionally, it is often localized to either or both temples or the forehead. The nature of the pain is usually described as squeezing or pressing, but sometimes throbbing (Meloff, 1982). The episodes are usually brief, no longer than one or two hours. The incidence of sleep disturbances may be more common with children experiencing tension headache as opposed to migraine headache, and the sufferer may often awaken with headache (Werder & Sargent, 1984).

Vascular Headache

The two major types of vascular headache most uniformly recognized are migraine and cluster. Although cluster headaches are rare in children (Terzano, 1981), they may emerge in late adolescence (Melhoff, 1982).

Melhoff (1982) indicates cluster headaches are believed to affect the internal carotid circulation and typically are consistent in being localized on one side of the face and head. The individual often awakens with this type of headache and they occur in season "clusters." usually in the spring and fall. Coddon (1982) describes the nature of the pain experienced by a cluster headache sufferer as like a knife or hot poker in the region of one or the other eye, lasting thirty minutes to two hours. He states the eye is usually inflamed and tears; the nostril on the affected side is usually clogged and has a clear discharge. Coddon states the condition has no hereditary link, it affects males 20 times more often than females, and lying down exacerbates the pain.

Migraine is the headache which has garnered the most attention by the scientific community. This may be due to its frequent severe and often debilitating nature for many sufferers. Meloff (1982) noted that although headaches in children are usually a benign symptom, they can produce considerable anxiety of symptoms that sometimes accompanies them, migraine headaches undoubtedly are major producers of this parental concern.

According to Meloff (1982), migraine is a form of headache which results from genetically predisposed irregularities in the intra and extracranial vascular system. These irregularities or perturbations are believed by some authorities to result from, or take the form of, an abnormality with serotenin metabolism (Barabas, Ferrari & Matthews, 1983). Serotonin is a component of blood which has vasoconstrictive effects on extracranial blood vessels. Intermittent serotonin depletion is believed by some to produce the migraine syndrome.

A report in Science Digest (1983) provides another description of the mechanics of migraine. With migraine, the blood vessels in the scalp shrink and swell in an alternating fashion. During the swollen stage this allows". . . certain biochemicals to seep through the vessel walls." These chemicals invade surrounding tissue and then ". . . initiate an inflammatory reaction which stimulates nerve endings to send a signal to the brain."

Migraine headaches are further divided into types by Meloff (1982) and include "classic," "common," and "complicated." He describes classic migraines as having a prodrome, or first phase, which includes symptoms of drowsiness, hunger, lassitude and mood changes. This is followed by a characteristic vasoconstrictive phase which produces an aura made up of visual disturbances and facial or limb dysesthesias (an inability to feel sensations (Davis, 1973). Throbbing headache pain accompanied by nausea and/or vomiting follows in the vasodilatation stage. This often results in several hours sleep for the child. Following sleep, the child may have recovered completely or experience a dull headache.

Meloff (1982) asserts the common migraine is equivalent to what is frequently called a tension-vascular or mixed headache. It produces a prodrome phase consisting of one or more of the following: malaise; visual disturbance such as spots or blurring; irritability; dizziness; or nausea. He further defines the common variety as less well localized than the classic, where pain is of a pulsating nature over an eye, in a temple or the forehead, and lateralized on the opposite side as the visual symptoms. The common migraine pain also lessens and increases and it may be accompanied by nausea and vomiting. Werder and Sargent (1983) indicate the common migraine occurs more frequently in children than does the classic. These authors also state childhood migraine frequently differs from the adult form by being bilateral as opposed to unilateral, or more brief duration, and occurring during the daytime as opposed to early morning wakeup onset. They also assert the pain may be more frequent, but less severe, accompanied by more pronounced abdominal symptoms and a less well-defined aura.

The complicated form of migraine is described by Meloff (1982) as including the relatively rare hemiplegic and opthalmoplegic forms and the more often encountered basilar artery form. The prepain phase of the basilar migraine results in vertigo, tinnitus, visual disturbances and occasionally the loss of consciousness. There follows the second phase which is characterized by occipital pain, nausea and vomiting.

There have been numerous studies aimed at determining incidence of migraine headache in children (Bille, 1962; Paulson, 1980) and they tend to average around seven to eight percent of the population. Werder and Sargent (1983) site work which indicates males have a higher incidence of migraine during early childhood. By adolescence, the male/female incidence rate equalizes and in adulthood it becomes considerably more frequent in females.

Tal, Dunn and Chrichton (1984), in their publication which speaks to differential diagnosis of childhood migraine, state family history of migraine is an often unreliable diagnostic criteria. They cite frequency of close family history varying from 14% to 90% according to Ziegler (1977). Most investigators and practitioners include a family history of migraine in their characteristics lists.

Precipitators or triggers for migraine include common environmental factors such as fatigue, allergy, stress, foods high in tyramine such as monosodium glutimate and chocolate, heat and exercise, head trauma, skipping meals, aspects of the menstrual cycle and oral contraceptives (Meloff, 1982; Podell, 1984).

Podell (1984) reports on a study of 74 children by Egger, Willson, Carter, et al. (1983) which demonstrated a significant number of victims had migraines triggered by such foods as cow's milk (27), eggs (24), chocolate (22), orange (21), wheat (21), bonzoic acid (14), cheese (13), tomato (13), yellow dye No. 5—tartrazine—(12), rye (12), and from seven to nine of the children studied; soy, corn, beef, pork and fish. Podell's conclusion was that for the sample studied, the link between diet and migraine was valid and that the variety of possible trigger foods was so great that any food or combination might be suspect.

If indeed tyramines are a causal factor for migraine, children—and adults— are exposed to a vast variety of foods besides chocolate and monosodium glutimate. Mirkin (1982) lists, in addition to these foods, cheeses, alcoholic drinks, avocados, raspberries, plums, papayas, bananas, raisins, canned figs, anchovies, pickled herring, yogurt, sour cream, aged meat, liver, and yeast extract as containing one or more of the chemicals found in the tyramine group.

Organic Headache

The term "organic headache" is meant to encompass those headaches resulting from a disease entity such as viral infection, structural physical defect such as brain tumor or vascular malformations, and head trauma.

Because of the potential life threatening element, the organic headache, though rare according to all authorities reviewed by this author, must be ruled out. This is a task for the medical community, but members of the medical community must first become aware of the suspect headache before they can address a differential diagnosis.

Tal, Dunn and Chrichton (1978) suggest the diagnosis of migraine or brain tumor must be differentiated from that of emotional problems. In their study of differential diagnosis, they found that of 82 cases of brain tumor, five children had presenting symptoms of a behavioral nature or mental deterioration.

Viral symptoms, including fever and limited range of neck motion when accompanied by headache, may signal meningitis, a potentially fatal disease (Arrowsmith & Burile, 1983).

Headaches exaggerated by coughing, sneezing, bending and straining, or accompanied by a newly acquired palsy of any kind could signify a tumor and would warrant immediate referral to a physician (Meloff, 1982). Increased severity of pain over time and in conjunction with movement or exertion and accompanied by nausea, vomiting, seizures, personality changes, change in consciousness level, neurological functioning or vital signs are also suggestive of intracranial pressure caused by an aneurysm or a tumor (Arrowsmith & Barile, 1983).

When a headache strikes that is unique to the individual because of its severe pain and sudden onset, a subarachoid hemorrhage could be present (Arrowsmith & Barile, 1983).

Previously undetected injury may be present according to Arrowsmith and Barile (1983) when headaches occur up to one month after a head trauma and it is in conjunction with nausea or vomiting, altered neurological functioning, changes in levels of consciousness, visual disturbances or loss of memory.

Psychogenic Pain Disorder Headaches

With a psychogenic pain disorder, headache pain cannot be described as vascular (migraine or cluster headaches) or muscular contraction headaches. The description is typically inconsistent with the anatomic distribution of the nervous system and no organic pathology or pathophyiological mechanism can be discovered to account for the pain. In addition, the complaint may be grossly in excess of what would be expected from physical findings of some related organic pathology (American Psychiatric Association, 1980).

Psychogenic pain disorder is differentiated from pain associated with tension headaches because in the latter there is a pathophysiological mechanism that accounts for the pain. It is differentiated from malingering in which the symptom production is in pursuit of a goal that is recognizable given the individual's voluntary. Although both are believed to be common in general medical practice, no prevalence figures are given for either malingering or psychogenic pain disorder. (American Psychiatric Association, 1980).

Environmental, Duplicative and Miscellaneous Categories of Headache

While some of the same mechanisms which are believed to be at the root of muscle contraction and vascular headaches may operate to produce headache pain in the environmental category, it is treated separately in this paper because of the unique causal factors.

Just as numerous foods are being suspected of contributing to migraine, allergies to other elements in the environment can produce headache through either the muscle contraction or vascular routes. Air pollutants such as carbon monoxide and sulfur dioxide, both found in great quantities in automobile and industrial emissions, can trigger headache (Coddon, 1982).

Mirkin (1982) notes a separate type of headache, caffeine withdrawal. Because caffeine is a vasoconstrictor, a large coffee or soda intake throughout the day results in blood vessels remaining constricted as a "normal" state. Abrupt elimination of the casseine containing food intake causes the vessels to suddenly lose their constriction and, in effect dilate. The effect is similar to the migraine vessel constriction/dilation process.

Practitioners may come in contact with parents or educators who state they suspect a child is experiencing "eye strain" headaches. While Mirkin (1982) indicates there may be a separate variety of headache resulting from vision difficulties per se, it is more likely the head pain is the result of the muscle contraction mechanism or a sinus congestion. Mirkin also groups headaches resulting from environmental pollution, such as fumes from ureaformaldehyde foam insulation, solvents and paints, and from inadequate ventilation as being tension-type headaches.

Psychogenic Headaches and Behavioral/Psychological Factors Related to Headache

Described as "vague" headaches occurring in children from whom physical examination and laboratory tests are negative, the psychogenic headache is frequently seen in children and may be related to depression, school phobia or failure experience (Mirkin, 1982). This headache phenomonen can be aggravated by handicapping conditions affecting learning or by social problems with parents or peers.

In reviewing the literature, this author did not find extensive data relating to psychogenic headache. There are, however, numerous studies dealing with psychological dimensions related to other recognized headache types. Cox and Thomas (1981) demonstrated that a reduction of headaches typically resulted in a reduction of depression. Ziegler, Rhodes and Hassanein (1978) had earlier found for all ages and sexes, significantly greater levels of depression in individuals who reported a history of severe or disabling headache as opposed to those denying a similar headache history.

It has also been cited by many researchers that there are personality traits and behavioral characteristics undeniably related to migraine sufferers (Price and Blackwell, 1980). Migraine patients are described as tending to be obsessive, unable to express emotion, perfectionistic, and anxious. Price and Blackwell's study demonstrated migraine sufferers did possess higher levels of trait anxiety than did normals and were more inhibited in the expression of their feelings.

Bakal (1981) proposes attending to the more encompassing psychobiological mechanisms relating to headache; most efforts to establish the significance of pathological emotions and personality traits in connection with headache have not yielded strong empirical relationships between psychological antecedents and the disorder. It is his contention that "behavioral medicine" which integrates the social, physiochemical and psychological components of illness and health in a holistic framework will be most promising, both in understanding and in treating headache.

Assessment

Because headache can have clearly serious implications, a youth's history with headache should be a component of any thorough child study. Information regarding headache can be obtained through direct interview with the youngster or, in the case of very young children, from parents. If headache appears to be a significant element by virtue of its frequency, intensity, circumstances or accompanying symptoms, some detailed information may prove helpful in making subsequent medical referral.

By employing a checklist or through some other method which addresses the facets of headache described earlier, the school psychologist will be in a position to advise parents and make needed referrals. The following could serve as a convenient format for collecting needed information:

HEADACHE ELEMENTS

1. Frequency;
2. Nature of the discomfort: A. Intensity: 1-slight, 2, 3, 4, 5-incompacitating; B. Location within the head;
3. Duration;
4. Onset;
5. Accompanying sensations, behavior or physical symptoms;

6. Post headache;

7. History (personality and family).

The school psychologist's next task, after gathering this information, would be to determine whether a referral is appropriate. While a knowledge of symptoms described earlier can serve as a partial guide, it could be argued that any significant headache warrants a medical referral. The extent of the psychologist's knowledge of headache would dictate the degree of insistence of urgency that might be exerted. Obviously, unusual headache dimensions or symptoms suggestive of tumor or infection require a medical referral. These would include such factors as stiff neck and fever or accompanying attacks of ataxia or other neurological signs.

Because medications such as analgesics may be appropriate and helpful treatment for even a benign, innocent headache, it would not be overly cautious to always refer parents to their physician or in some other way obtain medical involvement.

According to Meloff (1982), headaches can almost always be diagnosed by a detailed history and physical examination. A characteristic history with a normal neurologic examination will, in most cases, preclude elaborate investigations. Where called for, procedures such as lumbar puncture to rule out meningitis, skull x-ray, EEG, brain scans or CAT scales to investigate intracranial pressure are available. At the very least, the school psychologist when dealing with a child's headache symptom should seek consultation with a medical practitioner.

Intervention

With the cooperation of the medical community, appropriately trained school psychologists could enhance treatment for many children who experience headaches which interfere with their education or life skills acquisition. Treatment and interventions cannot be discussed without addressing the medical aspects.

Although medical treatment of headache is beyond the scope of this chapter, school psychologists should realize their complement of medical practitioners dealing with headache treatment. Since life style is a factor in the two most common headache types, muscle contraction or tension/stress headaches and migraine, school psychologists' training, perspective and position are appropriate to joint with physicians in helping the schools' headache sufferers. The school psychologist's expertise in modifying behavior, which may be precipitating or exacerbating headache in youth, should be made available to the sufferers, their parents and educators. The school psychologist is also in a favorable position to assist parents and youth with the anxiety they may experience over chronic or otherwise significant headache.

In a study comparing relaxation instruction and electromyographic (EMG) feedback training (Cox, Freundlich, & Meyer, 1975), both were found to be effective means of reducing headache. It was concluded that successful treatment was dependent on the patient learning EMG reduction, successfully increasing relaxation throughout daily activities, becoming able to recognize early onset of the headache, and being able to adequately apply relaxation skills early at the onset of the headache. Researchers cautioned that EMG feedback and relaxation instruction should be applied when the headache source was a high level neuromuscular mechanism and headache was not being maintained by secondary gains or the result of modeling.

Throughout the child evaluation process, the school psychologist is afforded information about the individual's life styles. If students interpret or experience excessive stress, investigation is warranted. Subsequent intervention of the school psychologist could be to assist the child in changing perception or stressors, thereby hopefully reducing the incidence of headache. It is possible that migraine may be relieved to some extent by increasing stress coping skills. Price and Blackwell (1980) speculate that migraineurs may respond to stressful stimuli physiologically, but may not respond verbally. They further suggest that if migraine sufferers could be assisted in increasing their verbal and/or behavioral responses, the physiological responses would be reduced.

Advances in biofeedback technology and its therapeutic application makes available a relatively new tool for practitioners who develop expertise in this field. There exists a wealth of resources which addressing aspects of biofeedback and its efficacy including Olton and Noonberg (1980), and Fischer-Williams, Nigl and Sovine (1981).

Thermal biofeedback training has proven most dramatically effective in the treatment of migraine (Green & Green, 1979). This process teaches the sufferer to "short circuit" the headache by warming the hands, raising temperature in the hands as a result of dilation of their blood vessels. Increased blood flow to the hands precludes the cerebral vessels expanding and, thus, the headache fails to develop or is less severe.

Werder and Sargent (1983), in their highly controlled study of 31 children over a three-year period, demonstrated that biofeedback (digital handwarming for migraine and frontalis muscle relaxation EMG for tension headache) and self-regulation (progressive relaxation, autogenic phrases, self-awareness and guided imagery) were useful for control of both migraine and tension headaches in children.

Biofeedback is frequently employed in conjunction with other methods of treating the stress response. As in the case of biofeedback literature, there are many sources of information on other stress reduction techniques (Everly & Rosenfeld, 1981; Phillips, 1978; Girdano & Everly, 1979; and Spielberger, 1979).

Conclusions and Considerations

Headache is a common ailment among children. In it's mild, innocent forms, it is bothersome, but of little impact. In it's more chronic and severe forms, it impacts on sufferers and their families in a myriad of negative ways, from impaired learning to impaired personality and behavioral patterns. The school psychologist has a valuable role to play in the study and treatment of headache in youth. The school psychologist should not unilaterally deal with headache because of the physical health elements inherent in this affliction, but certainly can become actively involved.

Headache is a far from perfectly understood phenomonen. It appears that medicine and psychology share interest in all aspects of this ailment—diagnosis, etiology, mechanics, and treatment. Obviously, training and discipline expertise will dictate who this common interest will be translated into action.

A collaborative approach which utilizes the potential contribution of both the medical and psychology professions would be most efficacious for the headache sufferer. Neither profession should be excluded from taking a responsible, appropriate role in addressing this disorder and it is imperative that school psychology strive to establish liaison with members of the medical community. Cooperative and consultation between the professions can marshall available forces and maximize the potential for relief from debilitating headache.

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Shy-Withdrawn Patterns of Behavior

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Abstract: This chapter reviews the definition, incidence, etiology and consequences of shy-withdrawn patterns of behavior. In addition, it reviews the assessment and diagnostic procedures used by school psychologists to determine whether or not a shy-withdrawn pattern of behavior exists in a particular student. Shy-withdrawn patterns of behavior are compared to other behavior disorders which produce similar symptoms and normal patterns of shy behavior are discussed. A case study is used to illustrate shy-withdrawn patterns of behavior. Numerous studies on intervention techniques are presented. Finally, this chapter reviews the methods used to monitor the effects of a psychological intervention.

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Background

Introduction

During most classroom discussions, there are a number of students who do not participate for a variety of reasons. Some of these students are unable to participate because they have not done their homework, perhaps they cannot read the material being discussed, or they are physically undernourished. Other students are unwilling to take part in a discussion because they are not sufficiently motivated or interested in the material being presented or they are, by nature, quiet and reserved.

There is yet another group of students who do have something relevant to contribute but are hesitant about doing so. Teachers and parents prefer that they speak up more often. These students, who have the ability and the desire to participate but are inhibited from doing so, are often referred to as shy and reticent (Friedman, 1980). Not only do these children hesitate to participate or interact with classmates and teachers but often have poor self-esteem and lack appropriate social skills.

Jimmy is an example of a shy-withdrawn child...

Jimmy is a ten-year-old boy from a small, rural town. The first born of three siblings, Jimmy is considered to be the "listener" in the family. He spends much of his free time reading about science and enjoys making things with his hands. Jimmy's mother describes him as creative and inventive, but also sensitive and easily frustrated. A perfectionist, who becomes upset if he is unable to do something right the first time.

At school, Jimmy gets good grades but is considered to be very shy and he has few friends. His teacher referred him for help in learning to "open up more". She indicated that Jimmy actually chokes up when he tries to speak in front of the class. Other students often feel compelled to speak for him. Jimmy's shyness is so acute that he is reluctant to use the phone because it "puts him on the spot".

Jimmy often puts himself down. He feels that he usually does things wrong and he often wishes that he were smarter, taller, and better looking. Although Jimmy indicates that he likes school and learning, he finds it pretty tough being himself and he often worries about things. Jimmy seldom expresses these feelings to others.

Such children often go unnoticed in the classroom because they do not present a problem to the teacher. Garrison and Cruickshank (in Callahan, 1979) pointed out that shy-withdrawn children are often overlooked as needing help because they conform most to the typical pattern of the classroom. More importantly, children, as well as adults, who label themselves as being shy report that they do not enjoy being shy. Approximately half of all children and adults consider shyness to be a personal problem. Zimbardo, Pilkonis, and Norwood (1975) stated, "It seems that people look back on the shyness of their youth with about the same tenderness that they recall adolescent pimples" (p. 69).

This chapter will explore the nature, assessment, and treatment of shy-withdrawn patterns of behavior. We will first examine the various definitions of shy and withdrawn behavior, the prevalence of shyness among children and adults, some explanation of causes of shy-withdrawn behavior, and finally, the positive and negative consequences of being shy.

Definition

A review of the literature has revealed several terms which are synonymous with the author's term "shy-withdrawn" behavior. In defining shy-withdrawn behavior, the authors have left some of these synonyms intact in direct quotations by other authors.

What is shy-withdrawn behavior? A review of the literature indicates that there is no simple answer to this question. Shyness is a complex pattern of responding, both verbally and non-verbally, and is manifested at physiological, cognitive, and behavioral levels (Zimbardo, 1977). Shy-withdrawn behavior can range from occasional bouts of shyness to an extreme form of withdrawal. Furthermore, shy-withdrawn behavior is often a symptom of many other deviant patterns of behavior.

The earliest recorded use of the word "shyness", according to the Oxford English Dictionary, was found in an early Anglo Saxon poem. It meant "easily frightened" (Zimbardo, 1977). The Webster's New Collegiate Dictionary (1973) states to be shy is to be timid, distrustful, circumspect, reserved, and even disreputable. Theorists have defined shyness as a type of social anxiety or a form of fear characterized by withdrawal from social interaction (Lazarus, 1982).

Numerous descriptors have been used to characterize shy withdrawn children. Kauffman (in Callahan, 1979) defined withdrawn behavior as that behavior which keeps people at a distance, both physically and emotionally. The person who is withdrawn lacks such social skills as looking at others, talking to others, playing with others, touching others, and responding to social invitations. Hewett (in Callahan, 1979) noted other characteristics of the withdrawn individual, such as failure to attend to the environment, daydreaming, and inability to recall. Quay and Werry (1979) refer to a Shyness Disorder in their classification system which characterizes shyness as avoidant behavior with strangers, blushing, being unable to speak and clinging and hiding behind others.

Most theorists agree that shy-withdrawn behavior is related to feelings of social inadequacy. Therefore, a number of researchers have attempted to devise operational definitions for shy-withdrawn behavior by determining what constitutes this lack of social responsiveness (Brulle & McIntyre, 1982).

Gottman (1977) based his definition of social isolation on sociometric measures and observations of children when they were alone or when they were interacting with other children or teachers. He found that those children who could be classified as shy, anxious, and fearful had the lowest scores on peer acceptance and were generally ignored by other children. However, no relationship was found between peer interaction.

Kohn and Rossman (1972) used a symptom checklist and a social competence scale to measure two dimensions of social-emotional functioning in preschool children. The symptom checklist assessed withdrawn behavior by asking such questions concerning the extent to which a child keeps to himself, plays with other children, takes part in activities, as well as questions concerning facial expression and awareness of surroundings.

While descriptions of shy-withdrawn behavior are generally useful, Brulle and McIntyre (1982) indicate that recent researchers have been more interested in comparing the behavior of withdrawn children with that of normal populations of children. They listed several researchers who stressed that children with rates of interaction below a certain percentage be considered as socially withdrawn and in need of some kind of intervention (Kale, Kaye, Whelan & Hoplins, and O'Connor in Brulle & McIntyre, 1982).

In this manner, Strain, Cooke and Apollini (1976) appear to have provided the most useful conceptualization of what constitutes shy-withdrawn patterns of behavior. Social withdrawal is used as a descriptor for individuals who (owing to constitutional and/or experiential deficits) demonstrates social performance judged deficient by social agents (e.g., parents and teachers) controlling the reinforcers available in their environment (p. 97).

Their criteria for identifying the withdrawn behavior are:

1) the occurrence of social behavior with peers as measured by its frequency, intensity, and/or duration;

2) the number of peers with whom interaction occurs; and

3) the extent to which social interaction can be maintained in a natural environment setting (p. 97).

Socially withdrawn behavior if further placed on a continuum that ranges between two types - Type I behaviors are demonstrated by children who have not yet learned the appropriate social skills necessary for mutually reciprocal interactions with other children, while Type II behaviors are demonstrated by children who have learned the appropriate social skills but do not behave in an appropriate manner.

Brulle and McIntyre (1982) provided for a further delineation of socially withdrawn behavior. They cited the research of Greenwood, Walker and Hops who distinguish between social withdrawal and social rejection. The socially withdrawn child has low rates of interaction due to a lack of social skills, while the socially rejected child attempts to interact with other children but is rejected by them.

The child's behavior, the peer's response to these behaviors, and a comparison with normal populations are indicated Brulle and McIntyre (1982) to be the primary factors to be addressed in any definition of withdrawn behavior. The conceptualization posed by Strain et. al. (1976) and Brulle and McIntyre's further delineation appear to have provided the most useful definition of shy withdrawn behavior at this time.

Incidence

Shyness, in one form or another, is a part of almost everyone's life. According to the Stanford Shyness Survey conducted by Zimbardo and his associates in 1975, 80% of approximately 5,000 respondents to the survey indicated that they had been shy at some point in their life, while 40% considered themselves to be presently shy (Zimbardo, 1977). About twenty percent considered themselves to be chronically shy, 60% occasionally shy, and 20% situationally shy. In other words, some people labeled themselves as shy while other labeled only their reactions to certain situations as shy. Only seven percent of all the respondents indicated that they had never experienced feelings of shyness. Zimbardo did not provide the respondents to his survey with a specific definition of shyness. Rather, respondents were asked to accept or reject the shy label. The survey also asked what kinds of people and situations made them feel shy, and what kinds of thoughts, feelings, actions, and physical symptoms were associated with their shyness (Zimbardo, 1977, p.13).

The Zimbardo survey was primarily concerned with feelings of shyness in adults. Lazarus (1982) attempted to survey the prevalence of shyness among children. In a sample of approximately 400 fifth graders, 38% of the children labeled themselves as shy, 28% felt that they were shy at least half of the time, 5% labeled themselves as almost always shy, and 2% felt they were shy all the time.

Shyness does not appear to be more common among females than males, although there is some conflicting data in this area. Zimbardo (1977) found no differences between sexes as to the prevalence of shyness in his major survey. However, he also sampled children from the fourth to the eighth grade. The incidence of shyness among fourth, fifth, and sixth graders was appropriately 40% (or the same as in the adult survey). However, the prevalence of self-reported shyness rose to 54% among seventh and eighth graders. This increase was accounted for by the adolescent girls in the sample. Zimbardo believed that teen-age girls may need to be considered more physically attractive than teen-age boys, thus leading to feelings of awkwardness and self-consciousness.

In contrast to Zimbardo's survey, pre-adolescent girls in Lazarus' survey labeled themselves as shy twice as frequently as did boys. Lazarus also presented some preliminary research which indicated that teachers nominate girls as most shy twice as frequently as boys, based on a number of specific criteria. Perhaps, it is more permissible in our society for girls to be shy. Therefore, they are more likely to label themselves or to be labeled by others as being shy on a survey. Shea (in Brulle & McIntyre, 1982) suggests that shy-withdrawn behavior tends to be associated more with girls and aggressive behavior more with boys because of societal-parental expectations. Because of these societal norms, boys are more likely to be referred for help if they exhibit shy-withdrawn symptoms. An analysis of the standardization data on the Burks' Behavior Rating Scale showed five times as many boys than girls were rated as showing shy behavior (Burks, 1982)

According to the above surveys, shyness appears to be very prevalent in our society. Almost half of the adults and children who responded to the surveys labeled themselves as shy. Shyness does not appear to be merely a childhood affliction, nor do only females exhibit shy-withdrawn patterns of behavior. However, shyness does appear to be more acceptable for females than males.

Etiology

Theorists have attempted to provide explanations as to the possible causes of shy-withdrawn behavior. The inheritance-trait, biological, and psychoanalytic theories seem to attribute the cause to factors within the individual while the behavioral and environmental theories focus on factors outside the individual.

One theory is that shy-withdrawn behavior is inherited. Much of the data on the heritability of shyness comes from the personality-trait researchers (Zimbardo, 1977). An individual's personality is considered to be made up of a number of traits. These traits are determined through the use of a questionnaire which is administered to the individual. The questionnaire items are then analyzed to determine the presence, as well as the strength or weakness, of these traits. It is then possible, according to these theorists, to correlate a child's and parent's scores to determine if the trait(s) is inherited.

Comrey and Jamison (in Friedman, 1980) suggest that certain children are more vulnerable to sources of stress. This "susceptibility to threat" trait is considered to be relatively consistent throughout life. Cattell (in Cattell & Cattell, 1969) distinguished between two personality traits relating to shy-withdrawn behavior - threctia (H-) which represents a shy, timid, threat-sensitive person and it's opposite, parmia (H+) which represents an adventurous, bold person. The H- person, because of their temperament, is more likely to withdraw from threatening situations. This temperament is assumed to be the result of an highly susceptible autonomic nervous system. Eysenck (in Brulle & McIntyre, 1982) also presented some evidence for the existence of the heritability of shyness. He indicated that some children may be predisposed to social introversion.

The obvious disadvantage of trait theories is that they do not rule out the effects of the child's environment. In other words, a child could acquire shyness from a parent through modeling. The authors support the idea of genetic predisposition. An individual could be born with a predisposition or strong potential for shy-withdrawn behavior. However, the realization of this potential depends on factors such as learning and the individual's environment.

Brulle and McIntyre (1982) listed biological factors as another cause of withdrawn behavior. They cited the research of Schulman who stated that any occurrence which interferes with the electro-chemical-biological reactions of the brain and central nervous system can result in disturbed behavior. Thus, shy-withdrawn behavior may be caused by brain injury or diseases of the central nervous system. Brulle and McIntyre (1982) cited several other researchers who suggest the neurological impairment or imbalance contributes to disorders such as childhood autism, emotionally disturbed behavior, and schizophrenia.

According to psychoanalytic theory, shyness is caused by a disturbance of the harmony between the id, ego, and superego. Shyness is assumed to be a reaction to the unfulfilled wishes of the id. Zimbardo (1977) presented several examples which represent psychoanalytically derived origins of shyness.

Shyness may occur during the oedipal period when a child's desire for the mother's total affection must be repressed, causing them to blame themselves for the rejection they perceive to be occurring. Shynes may also be caused by the person's preoccupation with self. Clinically shy patients are often preoccupied with themselves (e.g., narcissism) or have grandiose fantasies and spend much of their time in daydreaming and imagination. Finally, shyness may result when the psychological separation between mother and child occurs prematurely. The abandoned ego feels unable to cope with the uncertainties of life and withdraws.

Zimbardo (1977) pointed out that these psychoanalytic theories are based on case studies of patients whose lives are severely incapacitated by shyness and for whom professional help is clearly indicated. However, he believed that the psychoanalytic orientation is valuable in "sensitizing us to the need for insight into deeper conflicts, of which shyness may be a symptom" (p. 55).

According to behavioral theory, shyness is conceptualized as a learned reaction to social events. This learning may be the result of:

1) a prior history of negative experience with people in certain situations, either by direct contact or by watching others getting "burned";

2) not learning the right social skills;

3) expecting to perform inadequately and therefore becoming constantly anxious about one's performance; and

4) learning to put oneself down for personal inadequacies - "I am shy", "I am unworthy", "I can't do it", "I need my Mommy" (Zimbardo, 1977, p. 42).

Behaviorists believe that children who exhibit shy-withdrawn patterns of behavior have learned to respond to this manner through the positive reinforcement of these types of behavior. The obvious advantage to the behavioral approach is that children can learn more appropriate ways of responding to social events through a systematic treatment program. One might want to be aware, however, of research on adjunctive behaviors before attempting to institute a behavior management program. Adjunctive behaviors are those behaviors induced and maintained by a change in the reinforcement schedule (Brulle & McIntyre, 1982). Brulle and McIntyre discussed a teacher who instituted a behavior management program for a severely withdrawn boy. The boy was praised every five minutes if he participated in a classroom activity. The teacher's aide was then put in charge of the room; however, she was not aware of the reinforcement program. The boy began to exhibit withdrawn behavior when the schedule of reinforcement changed.

Many children enter kindergarten already exhibiting signs of shy-withdrawn behavior. Thus, the home environment has been suggested as a cause, or at least a contributing factor, in the development of shy-withdrawn behavior (Brulle & McIntyre, 1982). A parent may ascribe to the philosophy that "children should be seen but not heard" and this may cause a child to be very reticent (Friedman, 1980).

Schulman (1967) believed that "the basis for every behavior disorder is to be found in the relationship in the home, principally those of each of the parents with the child and the parents with each other" (p. 26). He listed ten possible relationships which could result in the development of withdrawn behavior. These relationships included those that were rigid, overpermissive, overprotect, rejecting, symbiotic, vicarious, inconsistent, neglectful, as well as relationships where the parents were psychotic or where there were marital problems. Burks (1982) also cited several researchers who reported that many shy-withdrawn children are raised by dominating and overprotective mothers who produce these symptoms in their children.

Zimbardo (1977) indicated that more research is needed on the influence of the home environment. However, he has found a number of factors which he believes may contribute to shyness in a child.

Self-image. Shy withdrawn behavior is often related to feelings of low self-esteem and social inadequacy. Zimbardo's research indicated that shy girls and boys feel that they are less popular (meaning less attractive, less intelligent) than other children. Solomon (in Zimbardo, 1977) found that shy children were less self-confident and more intolerant of others. Lazarus (1982) surveyed 500 fifth grade students and found significant correlations between shyness and low self-esteem. No significant sex differences were found for both self-esteem and shyness. However, fifth grade girls were more likely to perceive themselves as being shy and to be ranked more frequently within the shyest half of the class.

Birth order rank. Considerable research indicates that a child's order of birth in a family has a number of psychological and social consequences, one of which may be the development of shy-withdrawn behavior (Zimbardo, 1977). First birth children generally have lower self-esteem and feel more inadequate than later born siblings. Later born children are usually more popular and have more effective interpersonal skills. Miller and Maruyama (1976) sampled 1,750 children and found that later born children were more popular than their early born peers on measures of popularity in friendship, play, and school/work situations.

The most comprehensive data on birth order rank and shyness comes from the University of California Guidance Study (MacFarlane, Allen & Honzik in Zimbardo, 1977). Shyness information was collected on 252 children whose development was observed from the ages of 7 to 14. Their findings showed that girls are more shy than boys; first born girls are more shy than later born girls, and first born boys are more shy than later born boys. After age seven, however, shyness was not significantly related to birth order rank in boys and no shyness was reported in the sample of 14 year old boys. Since this information came from the mother's evaluation of shyness in her child, Zimbardo felt that they may have been reluctant to report this behavior in their sons.

Parental shyness. Zimbardo's research found that shyness of the parent and child was highly correlated. Seventy-five percent of shy children had shy mothers and fathers while 62% of shy children had shy mothers only. The siblings of a shy child tended not to be shy. A possible explanation for this findings is that shy parents will often have at least one child that is shy, probably the first born. Zimbardo felt that later born children are less shy because of lowered parental expectations and because the shy child has filled the role of the "quiet one" in the family.

The school environment has also been suggested as a causal factor in the development of shy-withdrawn behavior. The school setting may be particularly suspect if the child had shown no previous signs of withdrawn behavior. Brulle and McIntyre (1982) discussed two factors which might contribute to this behavior: 1) the rigid or unyielding teacher who pressures the withdrawn child to perform, and 2) the talented child who withdraws due to insufficient challenges. Children may even be encouraged to be shy and withdrawn. Many teachers value social skills in children that are related to taking responsibility, being obedient, and following rules and attach less value to skills that are related to taking initiative, being outgoing, and showing assertiveness (Cartlidge & Milburn in Friedman, 1980). Unfortunately, as Zimbardo (1977) pointed out, most teachers are unable to perceive shyness in their students. He cited several studies that have shown no relationship between teacher's predictions of shyness and self-reports of shyness by children.

A number of different explanations for shy-withdrawn behavior were presented in this section (that is, heredity, biological, intra-psychic, behavioral, environmental). Other possible causes for this behavior could have been discussed, such as the emphasis of our American value system on achievement and competition, family size and sociometric status, the high degree of mobility in our society, and the self-fulfilling prophecy of labeling (Zimbardo, 1977; Friedman, 1980). However, the purpose of this section was primarily to provide an overview of some of the more definitive research that presently exists in this area.

Consequences

It would seem that an individual has an unalienable right to be shy, just as another individual has an unalienable right to be outgoing and gregarious. An individual may even prefer being shy. Between ten to twenty percent of the 5,000 respondents in Zimbardo's survey indicated that they liked being shy (Zimbardo, 1977). Zimbardo pointed out that these individuals had discovered the positive side of shyness. Being shy increased their personal privacy and anonymity, it allowed them more selectively in relationships, and enabled them to act more deliberately and cautiously. In addition, teachers appear to prefer children who are compliant and unassertive in the classroom.

The feeling of being shy, however, is not enjoyed by most individuals. Seventy-five percent of those individuals who labeled themselves as shy on Zimbardo's survey indicated that they did not like being shy; this percentage rose to 90% for those individuals who no longer considered themselves to be shy (Zimbardo, Pilkonis & Norwood, 1975). Lazarus (1982) reported that 59% of the children who labeled themselves shy wanted to be less shy, 46% felt that being shy was a personal problem, and 47% indicated that they would like to participate in a counseling group.

Research cited by Brulle and McIntyre (1982) indicated that children who are not socially accepted in early grades experience later difficulties. Regardless of the cause of the withdrawn behavior, it restricts a child's access to appropriate reinforcement, which results in more withdrawn behavior. Friedman (1980) also presented a number of research findings which indicated that: 1) shy students often do not take advantage of the opportunities available to them in school; 2) they contribute less to a discussion and often their self-consciousness limits their ability to recall what has been discussed; 3) they avoid asking for help and often do not do as well as their less shy classmates; 4) they have more negative attitudes toward school; and 5) teachers often perceive them as having lower potential for achievement and success.

Strain and Fox (in Strain, 1981) indicated that children's withdrawn patterns of behavior become increasingly detrimental in the areas of language, cognition, social, and academic development. These withdrawn patterns of behavior which occur in childhood and adolescence are often the result of the following faulty learning processes:

1) Withdrawn children become increasingly ignored and rejected by other children since they do not engage in behaviors that are reinforcing to their peers;

2) Withdrawn children may quickly eliminate further attempts by classmates to play and be friends since they do not respond to their peers' positive social initiations;

3) Withdrawn children come to be viewed as individuals to be avoided through their misinterpretation of the overtures of peers and inability to clearly communicate their own behavioral intentions; and;

4) Withdrawn children have limited access to appropriate behavioral models and positive reinforcement by not being in close contact with peers (Strain & Kerr, in Strain, 1981).

Childhood withdrawal may often lead to later problems in adulthood. Strain (1981) presented results of retrospective and longitudinal research that has shown this to be the case. Withdrawn children were represented in greater proportions as adults who were dishonorably discharged from the military and as adults with mental health concerns and repeated run-ins with the law. A review of five studies by Goodman, Gonso and Rasmussen (in Greenwood, Walker & Hops, 1977) revealed that children who were assessed as unpopular by their peers on sociometric measures were disproportionately represented many years later on a county-wide psychiatric register. The research analyzed by Brulle and McIntyre (1982) did not show that all shy-withdrawn children exhibit later problems in adulthood but did show that many emotionally disturbed adults have been withdrawn as children.

Thus, the negative consequences of being shy and withdrawn appear to outweigh its positive aspects. In fact, withdrawn behavior seems to have a number of negative emotional, social, and academic correlates. Surveys clearly show that many children and adults do not enjoy being shy and that they would like some help in dealing with this problem. Shyness can be conquered, set aside, or outgrown. . . some 40% of survey respondents reported that they used to be shy but are no longer so (Zimbardo, 1977, p. 16). The next portion of this chapter will be concerned with the assessment of shy-withdrawn behavior, as well as the process of differential diagnosis.

Assessment

General Comments and Issues

When a student's shy-withdrawn behavior interferes with learning and emotional growth, it becomes relevant for the school psychologist to conduct an assessment. This assessment, at the most simplistic level, would lead to one of two possible conclusions: 1) The student appears to be shy and withdrawn but is mentally healthy, or 2) The student's shy-withdrawn behavior is a problem in and of itself or is symptomatic of problems in other areas. If the former is the case, then it may be the school psychologist's role to help the teacher realize that all children don't have the ability or desire to be social butterflies. In the case of the latter, the school psychologist needs to do a differential diagnosis.

Many of the issues in the assessment of shy-withdrawn behavior are identical to those in general psychological assessment, such as validity, reliability, and availability of normative data. Those issues will not be discussed here. The literature is replete with discussion over which is the more appropriate criterion for measuring social interaction/withdrawal and which aspects of social interaction are critically important for a child's development (Greenwood, Walker & Hops, 1977). The particular issues will be discussed as the specific assessment procedures are outlined.

Greenwood, Walker and Hops (1977) listed the following characteristics as elements for the ideal social assessment instrument:

> 1) The instrument should be capable of use for both screening/identification and treatment evaluation.
>
> 2) The instrument should bear a direct relationship to the behavior it is intended to select, predict, or measure.
>
> 3) Appropriate normative data should be available for decisions related to identification and/or selection of children to special training programs. . . . These data should include subjects from both normal and handicapped educational settings.
>
> 4) When used for screening/identification the instrument must show reliability over time to rule out error in measurement associated with the measurement occasion . . .
>
> 5) When used for screening/identification each child in the class would have an equal opportunity of being evaluated.
>
> 6) When used to assess change, the instrument can be applied in both group and single subject design strategies.
>
> 7) The instrument should be cost effective. . . . (p. 496)

Diagnostic Procedures

The procedures in the assessment of students with shy-withdrawn patterns of behavior fall into the following four categories: 1) direct observation, 2) behavior checklists, 3) personality instruments, and 4) sociometric measures. In addition, a student's performance on an intelligence test, such as the WISC-R, may reflect shy-withdrawn behavior. This will be discussed in the assessment portion of the case study of Jimmy. A parent interview may help the psychologist determine possible family variables affecting the student's behavior. Finally, the differential diagnosis of students who show shy-withdrawn behavior will be discussed.

Walker (in Greenwood, Walker & Hops, 1977) indicated observational measures to be an essential ingredient in the assessment of social interaction/withdrawal. Greenwood, Walker and Hops (1977) cited numerous studies which demonstrated the sensitivity of this type of measure to change in response to intervention.

However, Brulle and McIntyre (1982) pointed out the need to objectively and explicitly define the behavior when one uses direct observation. They qualify this by stating that explicitly defining behaviors may limit the number of characteristics which can be assessed. Brulle and McIntyre were referring to the various descriptors of shy-withdrawn behavior, such as sad, fearful, isolated, introverted, and quiet. The school psychologist may not have the time to operationally define and systematically observe all of these descriptors. However, shy-withdrawn students probably do not show all of the behaviors connoted by the term "shy-withdrawn". The format of the Walker Observation Form (1978) lends itself to the observation of students who are referred for shy-withdrawn behavior. For example, the percentage of social interactions initiated by a reference student during a free-time activity.

Brulle and McIntyre (1982) indicated that direct observation yields the most accurate information. However, they went on to say that teacher ratings have proven to be fairly accurate and much less cumbersome.

The following are some behavior checklists which can be used in the assessment of shy-withdrawn behavior:

1. Lazarus (1980) developed two instruments which were designed to assess shyness. The Shyness Self Report is an 18-item questionnaire which is administered to the student and focuses on the student's feelings, thoughts, and behaviors related to shyness. Lazarus also developed the Teacher Shyness Report which entails the rating of the observable behavior of the student by the teacher. The two shyness reports are supplemented with a Shyness Line and a Shyness Problem Line. The Shyness Line is a nine-point scale in which the student is asked to mark where they feel they belong according to the question, "Are you a shy person?" The Shyness Problem Line requires the student to answer the questions, "Is shyness a problem for you" The Shyness Line and the Shyness Problem Line could help the school psychologist determine whether or not a shy student shows good adjustment. In addition, the scoring system for the Shyness Self Report has ranges for "mildly shy", "moderately shy", and "severely shy". Lazarus indicated test-retest reliability to be .86. The authors, with the kind permission of Dr. Lazarus, have included copies of the shyness instruments in the appendix.

2. Brulle and McIntyre (1982) reviewed the Behavior Problem Checklist (Quay & Peterson, 1967). This checklist has a category which is comprised of anxiety/withdrawal. They indicated validity and the provision of norms for both sexes to be the strengths of the instrument. However, Brulle and McIntyre went

on to say that the items were taken from the most frequently reported behavior of children receiving psychiatric treatment at a clinic and may not correspond to behaviors which are prevalent in a school setting.

3. The Behavior Evaluation Scale (McCarney, Leigh & Cornbleet, 1983) is routinely used for students referred for psychological testing by the authors and their colleagues. Some of the items on the BES relate to the student's unwillingness to participate in class and to contribute to discussions. Scale 2, which relates to "an ability to build or maintain satisfactory interpersonal relationships with peers and teachers", appears to be the scale which most closely corresponds to shy-withdrawn patterns of behavior. The BES is given to the student's teacher and the teacher rates the student in terms of the frequency of behaviors tapped by fifty-two items. The authors of the BES did well in addressing the issues of validity and reliability in the test manual. The BES appears to be a good behavior checklist with respect to content validity, criterion validity, construct validity, and reliability. The BES was designed for use with students from kindergarten to twelfth grade.

4. Burks (1977) listed the Shy-Withdrawn child as one of the common patterns of behavior pathology seen in children. Burks indicated that the shy-withdrawn child will usually attain high scores in the following categories of Burks' Behavior Rating Scales: Excessive Withdrawal, Excessive Dependency, Poor Ego Strength, Poor Coordination, Poor Academics (sometimes), and Excessive Anxiety (sometimes). Burks indicated that the average item/item retest correlation coefficient for the BBRS was .705. The BBRS manual stated that the validity of the BBRS depends on five different sources: content validity, criterion-related validity, contrasted-groups validity, factorial validity, and construct validity.

5. The Walker Problem Behavior Identification Checklist (Walker, 1967) consists of 50 items. Scale 2 of the Walker is named Withdrawal and is comprised of five behavioral statements, each of which is weighted according to the author's estimate of the predictive importance of that particular item. The manual recommended that the Problem Behavior Identification Checklist be used for screening or identification of students who would benefit from further evaluation. The reliability of the instrument is reported in terms of split-half reliability (r = .98). The manual discussed four types of validity: contrasted-groups validity, criterion validity, factorial validity, and item validity.

6. The Internalizing scales of the Child Behavior Profile have different descriptors depending on factor loadings at each age level (Achenbach, 1979). Social withdrawal is regarded as a Mixed scale in boys aged 6-11. In other words, the scale reflects both

internalizing and externalizing characteristics at that age range in boys. Social withdrawal is classified as an Internalizing scale in girls aged 6-11. The Mixed scale named Hostile Withdrawal occurs on the edition of the Child Behavior Profile for boys aged 12-16 while the Internalizing scale named Depressed Withdrawal occurs on the edition for girls aged 12-16. The Internalizing scale named Uncommunicative occurs on both of the editions for boys. The Child Behavior Profile has a Social Competency section which entails rating the student on such things as amount and quality of student's participation in activities, membership and participation in organizations, and number of contacts with friends.

This discussion on behavioral checklists was not meant to exhaust all the possibilities but rather to provide [illegible] reasonable cross-section. Brulle and McIntyre (1982) commented that screening instruments most often assess aggressive behaviors rather than withdrawn behaviors. Perhaps the same can be said for personality instruments. The authors frequently use the Children's Personality Questionnaire (CPQ) (Porter & Cattell, 1968) in the assessment of students referred for behavior and adjustment problems.

The CPQ was designed for use with students aged 8-12. A Standard Ten Score (STEN) is reported for each of the 14 primary factors and each of the four second-order factors. The three primary factors, labeled Reserved-Warmhearted, Obedient-Assertive, and Shy-Venturesome, appear to be the factors which correspond most with shy-withdrawn patterns of behavior. In addition, there exists a second-order factor referred to as Extraversion. The Extraversion factor is comprised of different weights of the following primary factors; reserved-warmhearted, Obedient-Assertive, Sober-Enthusiastic, Shy-Venturesome, and Uncontrolled-Controlled. The CPQ manual appears to have good normative, validity, and reliability data.

The Early School Personality Questionnaire (ESPQ) (Coan & Cattell, 1966) is a downward extension of the CPQ and was designed for children 6-8 years of age. The Jr.-Sr. High School Personality Questionnaire or HSPQ (Cattell & Cattell, 1969) was designed for students aged 12-18.

Other personality tests in the assessment of shy-withdrawn behavior include projective techniques, human figure drawings, sentence completion tasks, and self-concept scales. One of the six interpretable factors on the Piers-Harris Children's Self-Concept Scale (Piers & Harris, 1969) is labeled "Popularity". The Popularity factor contains such statements as the following: "People pick on me", "I am among the last to be chosen for games"; "It is hard for me to make friends"; "I have many friends"; and "I feel left out of things" (p. 20). Those items which load on the Popularity Factor of the Piers-Harris appear to have some face validity in the assessment of shy-withdrawn students. Piers and Harris indicated in their test manual that the factors do not yield true factor scores. Cluster scores may be calculated for each factor. Piers and Harris cautioned the test user by pointing out that information from cluster scores is tentative but offers promise of being useful in further research.

Sociometric measures are one of the four assessment procedures outlined by Brulle and McIntyre (1982). The Behavior Rating Profile (Brown & Hammill, 1978) includes a sociogram based upon a peer nominating technique. Brown and Hammill provide a scoring system whereby raw scores can be converted to scaled scores. This is the only formal sociogram of which the authors are aware. There are many informal sociometric techniques and instruments which the school psychologist can use to assess students with possible shy-withdrawn patterns of behavior. The sociogram is valuable in differentiating between the student who is an isolate by choice and one who is an isolate by virtue of being rejected by peers.

Differential Diagnosis

The school psychologist, after having completed the assessment, will then begin the process of differential diagnosis. The purpose of differential diagnosis is to differentiate shy-withdrawn patterns of behavior from other conditions such as an adjustment disorder or school phobia. When other conditions are ruled out, the school psychologist can make intervention recommendations to help ameliorate a student's shy-withdrawn behavior.

The need for intervention would be based on whether or not a particular student's shyness is interfering with learning and/or adjustment. This process seems to presuppose that shy-withdrawn behavior exists as a separate entity. Goldfarb (in Sattler, 1974) indicated that one of the difficulties in differential diagnosis is that behavior disorders are not precisely defined entities.

This section will review some of the conditions which might be confused with shy-withdrawn patterns of behavior. However, Goldfarb's criticism should be kept in mind. In addition, remember that social responsiveness ranges from occasional shyness to extreme withdrawal, which may be included in many deviant patterns of behavior.

The DSM-III (1980) indicates that socially reticent children are "slow to warm up to strangers but after a short time can respond and suffer no impairment in peer interaction". This description appears to capture the essence of "normal shyness". The DSM-III differentiated socially reticent children from those having an anxiety disorder known as Avoidant Disorder of Childhood or Adolescence. The following is a description of the essential feature of the latter in DSM-III.

> The essential feature is a clinical picture in which the predominant disturbance is a persistent and excessive shrinking from contact with strangers or sufficient security so as to interfere with social functioning in peer relationships...(p. 54)

The DSM-III went on to say that these children desire affection, acceptance, and warm relationships. However, their reasons for avoiding the relationships which they desire may be interpersonal distrust, fear or humiliation, and alienated self-image (Millon, 1969).

In the case of Schizoid Disorder of Childhood or Adolescence, the individual has little desire for social involvement, as in the case of Avoidant Disorder of Childhood or Adolescence. The CPX, ESPQ, and HSPQ, which were discussed earlier, contain factors that measure an individual's desire for social involvement.

In the case of Adjustment Disorder with Withdrawal, according to DSM-III, the withdrawal is related to a recent psychosocial stressor. More specifically, the withdrawal is considered to be a maladaptive reaction to the stressor that occurs within three months of the onset of the stressor. Interviews with the parent, teacher, and student should rule in or rule out the existence of a stressor.

The DSM-III described a condition know as Social Phobia:

> The essential feature is a persistent, irrational fear of, and compelling desire to avoid, situations in which the individual may be exposed to scrutiny by others (p. 227).

So, in the case of Social Phobia, there is a strong and irrational fear of a specific object or situation. A case study by one of the authors (Polifka, 1981) described a popular 11-year old boy who was extremely fearful about reading orally in front of his classmates. This individual was otherwise reasonably outgoing and had good relationships with peers.

McDermott (1983) described an identifiable group of students for which he used the term Adequate Adjustment with Moderate Motivational Deficit:

> An observable, yet relatively adaptive, motivational deficit manifesting itself in a failure to respond to, or to seek out, stimulation in the school environment; primarily associated with boys vs. girls; sometimes seen as lethargy or laziness, but not considered significantly maladaptive (p. 256).

The authors, in the Introduction of this chapter, distinguished shy children from children who are unwilling to take part in a discussion due to lack of motivation and interest. This latter group appears to correspond to the group of students identified by McDermott. In addition, this group is characterized by a personality pattern which Millon (1969) refers to as "asocial personality". Some of their characteristics, according to Millon, consist of an affectivity deficit, complacent self image or lack of self-insight, and interpersonal indifference. An individual with those characteristics might be expected to attain a reasonably high score on a self-concept scale.

The authors entertained the theory that there exists a subgroup of apparently shy individuals who have an ulterior motive for this shyness. Perhaps some individuals feign shyness to manipulate others into doing things for them. A review of the literature revealed a personality pattern which is somewhat similar to the one theorized by the authors. Millon (1969) described a pattern which he referred to as the passive-dependent personality:

> Passive-dependent individuals often seek a single, all-powerful "magic helper", a partner in whom they can place their trust, depend on to supply the few comforts they want and to protect them from having to assume responsibilities or face the competitive struggle of life alone (p. 242).

However, according to Millon, the interpersonal style of the passive-dependent type is one of interpersonal compliance. Perhaps truly exploitive and seductive individuals happen to be extroverts.

Withdrawal and inactivity are sometimes associated with depression. However, Pearce (in Ford, 1982) indicated that in the case of depression, there is an association of depression, sadness, misery, or tearfulness with at least two of ten symptoms (for example, sleep disturbance, irritability, and suicidal thought). Ford (1982) pointed out that depression can occur in any diagnostic category. So, it would be important for the school psychologist to rule out depression when evaluating a student referred because of withdrawn behavior.

The school psychologist plays a major role in the identification of students with behavior disorders. One of the subgroups of students with behavior disorders, outlined in the definition (DPI, 1983), is comprised of students with "Cluster II" behavior characteristics. Those characteristics are "significantly deviant, withdrawn, or anxious behaviors". If a student's withdrawn behavior "deviates substantially from behavior appropriate to" his or her age and "significantly interferes with the learning process, interpersonal relationships, or personal adjustment", then the student is regarded as showing a behavior disorder. The differential diagnosis would consist of ruling out the other handicapping conditions (that is, mental disability, learning disability, and communication disability) as the cause of the withdrawn behavior. This would be differential diagnosis in the strictest sense of the law. However, it is essential to the well being of the student and in the spirit of good practice for the school psychologist to go beyond this basic level of differential diagnosis. For example, a student who does not show a behavior disorder may still be in need of an intervention to ameliorate the withdrawn behavior. It would then be necessary for the psychologist to determine some of the factors contributing to the behavior, in order to choose an appropriate intervention.

The following assessment procedures were used with Jimmy, the shy-withdrawn child introduced in the case study:

> The psychologist reported that Jimmy appeared to be tensing and was "choking" on words when he was trying to talk. His verbal IQ score was in the "Low Average" range. However, Jimmy was retested after the psychologist established more rapport with him. Jimmy then attained a Verbal IQ score which was in the "High Average" range.
>
> The Coopersmith indicated that things bother Jimmy, he finds it hard to talk in front of the class, he can't make up his mind, he gets upset easily at home. Responses to the When Do I Smile in the mid-range indicating no strong feelings either way. Responses toward school and learning were generally positive.

Some of the diagnostic conclusions were that Jimmy may have experienced an event that was traumatic to him. This event may have exacerbated his natural shyness.

Intervention

The authors of this chapter have found, from reviewing the literature, that shy-withdrawn behavior is not attributable to the same factors in all cases. Consequently, interventions focus on different factors which have contributed to shy-withdrawn behavior. More specifically, Friedman (1980) identified four different types of treatment for shyness and reticence in students. The types of treatment were listed in terms of the factors to which they address themselves: 1) decrease anxiety; 2) improve insight or understanding; 3) teach social skills; and 4) alter self perceptions related to self-confidence.

If a student's shyness is believed to be due to anxiety, then it would not make sense to focus treatment on the teaching of social skills, unless the student also happened to be deficient in social skills. However, some of the treatment techniques focus on several of the factors listed by Friedman (1980).

This section will provide the reader with an overview of the intervention techniques used for shy-withdrawn students. The interventions will be presented in terms of the methods and measurements used and the results, whenever this format is possible and appropriate. The intervention techniques are teacher-directed activities, cognitive behavior modification, assertiveness training, humanistic techniques, modeling and operant techniques, and activity as the intervention.

Brulle and McIntyre (1982), in a review of the treatment literature on socially withdrawn children, found that behavioral treatments were the most widely used. The authors of this chapter also found this to be the case. Therefore, more of the discussion in this section will focus on behavioral interventions, in comparison to interactions developed from other conceptual models.

Teacher-Directed Activities

The psychologist who conducted the evaluation with Jimmy recommended an intervention which the teacher was able to carry out with relative ease. It just happened that Jimmy's teacher was directing a play in her classroom. The psychologist recommended that Jimmy be given a role in the play. The script created a structured situation which provided Jimmy with something to talk about. More importantly, playing a role was less threatening for Jimmy than talking spontaneously. The assessment revealed that Jimmy had positive feelings toward school and learning. However, he found it difficult to talk in front of the class. This intervention appeared to be tailored to Jimmy's needs.

Kransler, Mayer, Dryer & Munder (in Brulle & McIntyre, 1982) compared the effectiveness of counseling, teaching-directed activities, and no treatment. Students in the counseling group participated in client-centered procedures once a week. In the teacher-directed activities group, the teachers were given a list of suggestions (for example, praise the student when he or she talks in a group). The students who received no treatment served as the control. A measure of sociometric status was used. The results indicated that there was no significant difference between the counseling group and the teacher-oriented activities group. Both treatment conditions were more effective than the control condition.

Teacher-directed techniques can be developed from several theoretical models. For example, the principles of play therapy developed by Axline (1947) are adaptable as teacher-directed activities. Guerney and Flumen (in Brulle & McIntyre, 1982) trained elementary teachers to effectively use play therapy in increasing the classroom assertiveness of withdrawn children.

Cognitive Behavior Modification

A study conducted by Harris and Brown (1982) compared cognitive behavior modification (CBM) to informed teacher treatment and a control condition for shy fourth, fifth, and sixth grade students. The specific components of the CBM program were developed in accordance with suggestions which were made by Meichenbaum, Meichenbaum and Cameron, and Weissberg (in Harris & Brown, 1982), to wit: 1) systematic desensitization to decrease anxiety; 2) cognitive restructuring to replace negative self-statements; and 3) modeling to help the subjects develop a set of positive self-statements. The CBM sessions took place over a duration of five weeks and consisted of ten, 45-minute sessions. The informed teachers were given information on classroom techniques for reducing shyness. The Measure of Elementary Communication Apprehension was used as the instrument in comparing the techniques. This instrument was described as consisting of 20 Likert-type statements, with smiling and frowning faces representing the choices.

The results of Harris and Brown's study were that the mean score on the instrument for the informed teachers group was not significantly different from that of the control group. However, the mean of the CMB was significantly lower than that of the informed teachers. In other words, only CBM significantly reduced fear of social and public speaking situations.

Assertiveness Training

Leone and Gumaer (1979) used group assertiveness training (AT) to teach 11 shy students effective ways of communicating. The students were identified on the basis of teacher observations, sociometric data, and counselor and teacher consultation. Leone and Gumaer's sessions were conducted in two phases. The first phase consisted of twelve 40-minute sessions while the second consisted of six 40-minute sessions. The components of the intervention included: reinforcement procedures, relaxation and guided fantasy, behavior contracts, video models, role playing, and focused feedback. The instruments used to measure the effectiveness of the intervention were: 1) the Coopersmith Self-Esteem Inventory (Coopersmith, 1967); 2) an anxiety scale; 3) a teacher checklist; and 4) a sociogram.

Leone and Gumaer (1979) reported no significant differences on the pre- and posttest measures of the anxiety scale and sociogram. However, they indicated that the anxiety and social status mean score for shy students increased in the desired direction. Significant differences between pre- and posttest measures on the teacher checklist and the Coopersmith were reported. The researchers contended that shy students increased their self-confidence and, in turn, were able to assert themselves. Consequently, the students were recognized more by teachers.

Lazarus (1977) used a broad-spectrum intervention which included the following components: assertiveness training, role modeling, social skills training, humanistic techniques, fantasy, and attending and listening skills training. The subjects consisted of 98 fifth grade students who were identified by themselves, and by their teachers, as shy. Students in the treatment group met from 30-40 minutes twice a week for seven weeks.

Lazarus (1977) found significant differences between the experimental and control groups on the Shyness Teacher Report, Teacher Shyness Change Rating, and the Simulated Assertiveness Situation Test. However, he found no significant difference between the two groups on the Shyness Self Report, Shyness Line, Shyness Problem Line, and Coopersmith.

Humanistic Techniques

Kaczmarek and LeVine (1980) conducted a single case study in which they used expansion training as an intervention with a rigid, withdrawn eight year old male student. They presented expansion training as a new model which incorporates modeling techniques and humanistic techniques. The modeling techniques were used to help the subject to develop spontaneous behavior while the humanistic techniques were used to help the subject expand his awareness of options. More specifically, Kaczmarek and LeVine stated that many withdrawn individuals are rigid in their thinking. This rigidity, they contended, renders the student unable to use a variety of response patterns.

Frequency of temper tantrums and frequency of going out for recess were used as a measures of effectiveness of the intervention. Prior to the intervention, the subject did not want to go out for recess at all and was prone to having temper tantrums. This study included neither a base line, nor a post-treatment measure for the temper tantrums. The treatment consisted of weekly 30-minute sessions over a duration of 13 weeks. Subsequent to the intervention, the subject attended recess at least twice a week. In addition, it was reported that he had learned to verbalize his difficulties in adjusting to change, as opposed to having a temper tantrum.

Some of the specific techniques used by Kaczmarek and LeVine (1980) in their case study included: 1) modeling spontaneous playful behavior; 2) verbal reinforcement of any positive, active and spontaneous behavior shown by the subject in sessions; 3) modeling and role-playing of alternative ways of handling conflicts, by the counselor; and 4) modeling and role-playing of conflict situations which successively approximate the subject's concern. Kaczmarek and Levine indicated that the counselor does not actively involve parents or teachers to reinforce or monitor the subject's behavior. However, they indicated that the parents did seek out the counselor at the end of the treatment duration to discuss the changes observed by the parents. The issues of treatment generalization and long term follow-up were not addressed in a specific manner. However, the authors of the study seemed to imply that generalization took place.

Brulle and McIntyre (1982) cited several studies in which therapeutic sports activities were shown to help withdrawn adolescents gain self confidence and make new friends (Doxier, Lewis, Kersey & Charping in Brulle & McIntyre, 1982).

Modeling and Operant Techniques

Modeling, which is based upon the principles of social-learning theory, can be used to establish new response patterns, to condition emotional responsiveness, and to extinguish certain behaviors (Bandura, 196). This technique can be used alone or with shaping (O'Connor, 1972).

O'Connor (1972) investigated the effects of filmed modeling and social reinforcement on the behavior of nursery school children. The 33 social isolates in this study were selected on the basis of their being observed to interact with peers no more than 15% of the time. The percent of time which the subjects spent interacting with peers was used as the measure to assess treatment effects.

The treatment group in O'Connor's study viewed a modeling film while the control group viewed a film about dolphins. Condition assignments were as follows: 1) modeling and shaping; 2) modeling only; 3) control film and shaping, and 4) control film only. The subjects in the shaping conditions received a total of five hours of shaping, praise and attention over a duration of two weeks.

O'Connor (1972) was able to show that subjects in the modeling group performed better than those in the shaping and modeling and shaping groups. In addition, a 9-week follow-up assessment revealed that subjects in the modeling groups remained at the level of nonisolates, while subjects in the shaping and control groups returned to the isolate level.

Conger and Keane (1981) conducted an extensive study of studies on social skills intervention. They systematically reviewed ten studies in which the investigators used several varieties of modeling alone, or modeling in combination with operant procedures. They found that some of the techniques held promise; however, their conclusions were limited due to methodological problems in the studies which they sampled. In addition, Conger and Keane (1981) pointed out a lack of basic research designed to ascertain the components that comprised social skills.

In a case study conducted by Kirby and Toler (1970), a five year old nursery school boy with a low rate of social interaction was induced to pass out one of several choices of candy as a technique to increase his rate of interaction with peers. The percentage of the subject's time spent with other children was used as the pre-and post-intervention measure. Treatment consisted of three components or phases: 1) The teacher gave the subject explicit and detailed instructions on how to pass out the candy each morning for a period of five days; 2) The procedure of passing out candy was reinstated for five days, subsequent to a five-day reversal to base line; 3) The subject was given candy to pass out on only two of five school days to thin out the schedule of reinforcement. The total duration of the intervention was 25 days, counting base line and reversal. Part of the procedure entailed the subject's asking peers for their candy preferences to ensure a verbal interaction.

Kirby and Toler (1970) reported that the subject's interaction with peers increased markedly during the periods in which he passed out the candy. In addition, they reported that proximity and cooperative play showed the most change. The number of activities which the subject initiated rose steadily throughout the experiment. However, verbalization remained low. The authors of this case study did not mention whether or not they conducted a post-intervention follow-up.

The main rationale for the treatment, stated by the authors, was that by passing out a primary reinforcer to his peers, the subject may have acquired secondary reinforcing characteristics. Thus, peers would be more likely to interact with him. The authors of this chapter question why the experiment did not include a total phasing out of the candy. These authors maintain that our circle of friends would expand dramatically during a period of handing out ten-dollar bills. However, the crucial question would be whether or not the secondary reinforcing properties would remain in effect, subsequent to a more penurious life style! On the positive side, this technique required relatively little of the teacher's time, since it did not depend on teacher attention as a reinforcer.

Walker and Hops (1972) compared individual and group reinforcement contingencies in the modification of social withdrawal in three first and second grade students. The Walker Problem Behavior Identification Checklist (Walker, 1967) was used to identify the students. The rate of social interaction was used as the measure in this study. More specifically, an interaction was defined as a "reciprocal social exchange between two students". In addition, an estimate of group social interaction was used in this study.

The procedure was divided into the following three experiments: 1) social skills training for the subject via symbolic modeling, followed with a procedure in which the subject earned points when she got a peer to initiate a social interaction with her; 2) the reciprocal of condition (1) above, that is, the peers received the skills training; and (3) a combination of (1) and (2) above.

Walker and Hops (1972) found that individual token reinforcement, group token reinforcement, and a combination of the two, all increased the subjects' social interaction rates. However, the condition which was a combination of the group and individual contingencies produced the most marked change in the subjects' social interaction rates.

Activity as the Intervention

The effects of socialization with a younger child, socialization with an age mate, and no treatment on the sociability of 24 withdrawn children was investigated in a study by Forman, Rahe & Hartup (1979). Percent of peer interaction was used as the measure in this study. More specifically, the authors computed the percentage of reinforcement, neutral acts, and punishment for isolates and their nonisolate peers, before and after treatment. The treatment consisted of ten play sessions scheduled over a period of four to six weeks. Each isolate and their nonisolate partner were given the opportunity to play with two toys for about 20 minutes.

Furman, Rahe & Hartup (1979) found that the treatment, particularly the mixed-age condition, increased the sociability of the subjects in their classrooms. They reported that reinforcement rates were tripled among subjects included in the same age condition. The control group showed no change. The researchers hypothesized that younger children provided the isolates with more opportunities to show initiative and leadership, in comparison with the same-age children.

Concluding Remarks about Intervention

These authors have reviewed numerous interventions designed to increase the sociality of shy-withdrawn students. Methodological differences would preclude the systematic ranking of these interventions, with respect to relative efficacy. However, there are several factors to consider when choosing an intervention. The following are factors to take into consideration: 1) the social skills component(s) in which the student shows a weakness; 2) the age of the student; 3) degree of expertise of the person implementing the intervention; and 4) time considerations. If a preschool student has reasonably good social skills but is not assertive enough to apply them, then it would seem appropriate and time-efficient for the school psychologist to help the teacher in arranging some sessions of socialization experience with a younger child. However, a student with deep-seated anxieties about social situations may need to be referred to a counseling agency.

Monitoring Methods

All of the authors reviewed within this chapter applied their monitoring methods to behavior which is the opposite of shy and withdrawn behavior. For example, some of the researchers measured the percent of time the subjects spent interacting with peers before, during, and after treatment. Another researcher used the percent of time the subject spent in proximity to other children as the measure. The frequency with which a student initiates social interactions is yet another measure which can be used. A professor which one of these authors had in graduate school advocated the "dead person's rule" in defining and monitoring behavior. This rule simply states that the behavior should not be defined in terms of behavior which could describe a dead person. For example, it would be relatively easy for a dead person to show withdrawn behavior or to not initiate any social interactions.

Some of the researchers used measures other than measures of overt behavior to monitor the effectiveness of their interventions. For example, one researcher used a self-esteem inventory, an anxiety scale, a teacher checklist, and a sociogram. The main advantages of teacher checklists is that they can be reasonably accurate and are time-efficient.

In the case of Jimmy, the teacher simply reported that Jimmy's spontaneous speech in the classroom improved. In addition, she reported that Jimmy developed a sense of pride in knowing the answers to questions.

Some of the authors reviewed in this chapter did not address whether or not a long-term follow-up assessment was conducted. O'Connor (1972), however, conducted a nine-week follow-up assessment in his study.

Conclusions and Considerations

These authors have found a student's behavior, peer's responses to these behaviors, and a comparison with normal populations to be the most useful components of a definition of shy-withdrawn behavior. Several factors in the etiology of shy-withdrawn behavior were reviewed. Shy-withdrawn behavior can be viewed within the context of the nature-nurture issue, as is the case with other patterns of behavior. Shy-withdrawn behavior should not be viewed as having one, and only one, cause. It can more realistically be viewed as the result of several causal factors.

The consequences of shy-withdrawn behavior were reviewed in this chapter. These consequences range from no significant negative consequences to significant impairment in academic functioning and/or interpersonal relations.

Social skills are comprised of several components. There does not appear to be consistent agreement, among researchers, as to what these components are. However, Friedman (1980) offered a scheme which might be useful in guiding the diagnostician and in choosing an intervention. More specifically, the interventions were classified in terms of whether they: (1) teach social skills; 2) reduce anxiety; 3) alter self-perceptions related to self confidence; or 4) improve insight. If the assessment reveals that a student is shy-withdrawn because of a lack of social skills, then the intervention should focus on the teaching of social skills. However, many of the interventions which were reviewed in this chapter focused on several of the factors contributing to shy-withdrawn behavior. Realistically, students who are deficient in social skills may lack self-confidence and insight. In addition, social situations may serve as anxiety-arousing events.

Finally, a shy-withdrawn behavior may be symptomatic of other behavior disorders. For example, it is important that the school psychologist take steps to ensure that depression is ruled out before planning a regimen of social skills training or other interventions.

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SHYNESS SELF REPORT

Think about these and decide how you act and feel. Circle your answer.

1. If the children are playing on the playground, and you want to play with them, do you go over and ask to play?

   Never Almost Never Sometimes Often Always

2. If your teacher asks a question in class and you think you know the answer, do you raise your hand to answer?

   Never Almost Never Sometimes Often Always

3. If the teacher needs a volunteer for a special task, how often do you volunteer?

   Never Almost Never Sometimes Often Always

4. If someone cuts in front of you in line, do you try to hold your place?

   Never Almost Never Sometimes Often Always

5. If children are talking at school, and you would like to join them, do you go over and talk?

   Never Almost Never Sometimes Often Always

6. If a boy or girl takes something that belongs to you, do you try to stop him?

   Never Almost Never Sometimes Often Always

7. If you want to speak to the teacher in private, do you go and speak to her?

   Never Almost Never Sometimes Often Always

8. Do you speak in class discussions?

   Never Almost Never Sometimes Often Always

9. Do you feel shy with grown-ups?

   Never Almost Never Sometimes Often Always

10. Do you feel shy with boys in your class?

    Never Almost Never Sometimes Often Always

11. Do you feel shy with your close friends?

    Never Almost Never Sometimes Often Always

12. Are you a leader with children your own age?

Never Almost Never Sometimes Often Always

13. Do you feel shy with girls in your class?

Never Almost Never Sometimes Often Always

14. Are you good at making new friends?

Never Almost Never Sometimes Often Always

15. Do you look directly at someone when you speak to them?

Never Almost Never Sometimes Often Always

16. Do you speak in a loud enough voice so everyone can hear you?

Never Almost Never Sometimes Often Always

17. Are you quiet with other children when you would rather be speaking?

Never Almost Never Sometimes Often Always

18. When you want something, are you able to ask for it?

Never Almost Never Sometimes Often Always

TEACHER SHYNESS REPORT

1. Is able to speak up in class.

Never Almost Never Sometimes Often Always

2. Speaks in a low speaking voice.

Never Almost Never Sometimes Often Always

3. Is timid in social situations.

Never Almost Never Sometimes Often Always

4. Is able to establish eye contact with others.

Never Almost Never Sometimes Often Always

5. Is able to initiate contact with other children.

Never Almost Never Sometimes Often Always

6. Is able to stand up for his/her rights.

Never Almost Never Sometimes Often Always

7. Is able to express his/her opinion freely and openly.

Never Almost Never Sometimes Often Always

8. Is quiet in social situations.

Never Almost Never Sometimes Often Always

9. Tends to withdraw from social contact.

Never Almost Never Sometimes Often Always

10. Will volunteer in class.

Never Almost Never Sometimes Often Always

11. Is shy with members of the same sex.

Never Almost Never Sometimes Often Always

12. Is shy with adults.

Never Almost Never Sometimes Often Always

13. Is hesitant to speak in social situations.

Never Almost Never Sometimes Often Always

14. Expresses leadership when it is necessary.

Never Almost Never Sometimes Often Always

15. Is shy with members of the opposite sex.

Never Almost Never Sometimes Often Always

16. Is able to ask for what he/she wants.

Never Almost Never Sometimes Often Always

17. Is able to initiate friendships.

Never Almost Never Sometimes Often Always

18. Appears self-conscious in social situations.

Never Almost Never Sometimes Often Always

Name____________________

SHYNESS LINE AND SHYNESS PROBLEM LINE

Mark Where You Feel You Belong on These Lines

Are You A Shy Person?

____

Always Shy	Usually Shy	Slightly Shy	Almost Never Shy	Never Shy

Is Shyness a Problem For You?

____

Always a Problem	A Large Problem	A Small Problem	Almost Never A Problem	Never A Problem

Seizure and Convulsive Disorders

David Happe

Abstract: This chapter presents information describing the medical diagnosis and treatment of the convulsive disorders. The ramifications of the disorder and its treatment in the school setting are discussed. Recommendations for the school psychologist and other support personnel are provided for dealing with the child who suffers seizures as well as parents and teachers.

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Introduction

"Oft too some wretch, before our startled sight, struck as
with lightning, by some keen disease
Drops sudden: - by the dread attack o'er powered
He foams, he groans, he trembles, and he faints;
Now rigid, now convulsed, his laboring lungs
Heave quick, and quivers each exhausted limb,
Spread through the frame, so deep and dire disease
Perturbs his spirit; as the briny main
Foams through each wave beneath the tempest's ire.
But when, at length, the morbid cause declines,
And the fermenting humors from the heart
Flow back - with staggered foot the man first treads,
Led gradual on to intellect and strength.
(Lucretius, 95 BC)

Possessed by dieties by some accounts (epilepsy was once known as the "sacred disease"), by demons in others, victims of uncontrolled convulsive disorders have always been viewed with a certain awe by society. The passage above captures the dramatic nature of a grand mal seizure. The immediate cause for this powerful event and all other seizures is the abnormal discharge of nerve cells in the brain. The result of this altered brain activity can range from a simple twitch to a protracted life threatening situation.

Seizure disorders have stricken such notables as Van Gough, Handel, Nobel and Dickens and are believed to affect approximately 0.5 to two percent of the general poupulation (Freeman, 1979; Wolraich, 1983). Two-thirds to three-fourths of initial seizures occur in the preschool and school years (Freeman, 1979) and a seizure disorder may have a significant impact upon the developmental, intellectual, social, emotional and academic well-being of a child. Needs for assessment, intervention, consultation and inservice education may draw upon all the skills of a school psychologist.

Definitions

A convulsive or seizure disorder can be defined as a "paroxysmal, transient alteration of brain function that begins and ends spontaneously and has a tendency to recur" (Berg, 1982). The alteration of brain function can be manifested in a wide variety of behavioral and motoric disturbances and the disruption of the normal electroencephalographic (EEG) pattern. Strictly speaking the term "seizure" refers to the abnormal electrical activity of the brain and "convulsion" refers to the abnormal motor activity which may result. This distinction can be an important one as not all seizures are accompanied by convulsions. However, common usage has so clouded the distinction between these two words that no attempt will be made here to preserve the difference and "seizure" and "convulsion" will be used more or less interchangeably.

"Epilepsy" is a term which can be used to denote any disorder which has the sympton of recurrent seizures. That is, epilepsy is not a unitary disease entity but a group of related disorders. The origin of the term has been attributed to both a Greek word meaning to be attacked or seized and the Latin for "falling sickness". While the term "epilepsy" is applicable to almost all seizure disorders its use is restricted in common practice. Many parents, patients and physicians feel that "epilepsy" carries a connotation of mental handicap and terms viewed as more acceptable, such as "seizure disorder" are used. When the term is used it is more frequently applied to seizure disorders of unknown cause and to seizure disorders which develop following some acute traumatic episode such as a head injury or febrile disease than to seizures which accompany an identifiable, chronic condition. A person suffering from tuberous sclerosis and recurrent seizures as a result may be said to have epileptic or epileptiform seizures but not epilepsy, per se. The difficulties posed by the number and usage of terms relating to seizure disorders will be addressed frequently in this chapter.

A model of human epilepsy

The delineation of convulsive disorders as being a neurological condition was accomplished in the middle 1800s but the precise mechanism responsible for the initiation of a seizure is still unknown. A model which accounts for the development of recurrent seizures has been proposed. This "kindling model" is based on the results of laboratory studies of animals (Goodard, 1983). Electrical stimulation at a level of intensity which produces little change in behavior when applied for a few seconds each day will eventually produce seizures. This kindling effect has been observed to occur when the stimulation is applied to many different areas of the brian and in a variety of animal species. Other forms of stimulation have also been shown to produce kindling-type responses. These include intense auditory stimulation, administration of a number of different types of drugs and repeated inhalation of industrial solvents. The change which is produced by the kindling stimulation appears to be very durable. Very long interruptions between successive stimulations do not affect the disposition to seizure once it has been established. It does not appear that kindling occurs as a result of damage at the stimulation site but rather from a functional change at the site. The stimulation causes neuronal change making the site susceptible to the initiation of seizures.

It is important to note that laboratory induced kindling rarely produces spontaneously recurrent seizures in animals. It does, however, produce a site which is prone to seize under the kindling stimulus as well as other forms of stimulation. If a pathological condition exists which triggers recurrent seizure activity then kindling may occur. That is, over time a seizure disorder may fail to improve or become progressively worse not because the underlying pathology is still present or has worsened but rather because the tissue stimulated by the abnormal electrical discharge of seizures has become sensitized to seizure provoking stimuli. An individual may suffer seizures initially due to irritation by bone fragments, hemmorhage or other factors directly related to a trauma. The healing process may remove these immediately provoking agents but the seizure activity itself may kindle an area of the brain which remains prone to seizure. Seizures could then be provoked at a later time due to metabolic imbalance, high fever, toxicity or other factors. There is some evidence that prophylactic anticonvulsant drug treatment following severe head injury is effective in reducing the incidence of post-traumatic epilepsy (Goddard, 1983). If the medication is effective in preventing seizure activity the abnormal electrical activity which could cause kindling simply does not occur.

Causative factors

While the immediate neurological cause of a seizure remains unknown many of the events and conditions which result in the development of a seizure disorder have been identified. Table 1 provides a listing of some of the major identified causative factors. These causative factors are primarily inherited disorders or syndromes and neurological insults such as injury or disease. The fact that males suffer more seizure disorders than females in the ratio of 100:77 (Berg, 1983) is due to differential exposure to some causative factors. The greater likelihood of male adolescents and young adults suffering head trauma from auto and motorcycle accidents and contact sports accounts for much of the difference. Despite the many known causes of seizure disorders 25 to 50 percent of epileptic disorders have no known cause (Gadow, 1979).

Table 1: Factors related to the development of seizure disorder

Prenatal factors
    Inherited metabolic disorders (e.g., galactosemia)
    Maternal infections (herpes, toxoplasmosis, syphylis)
    Placental insufficiency
    Prematurity
    Maternal hormonal imbalance
    RH incompatibility
    Teratogenic drugs
    Chromosome disorders
    Inhereited epileptiform EEG traits

Prenatal factors

    Head trauma at birth
    -small birth canal
    -use of forceps
    -breech presentation

Anoxia

Postnatal factors
- Infections
  - -Parasitic
  - -Encephilitis and meningitis

Cerebral Palsy
Toxic doses of certain drugs or heavy metals
Brain tumors
Prolonged high-grade fever
Oxygen deprivation
Head trauma

Precipitating factor

A number of factors have been shown to precipitate attacks in seizure-prone individuals. These factors (see Table 2) may provide clues to intervention though enviornmental modification, stimulus control or changes in the care routine. For example, restricted fluid intake or increase in medication for the days before, during and after menses may control seizures in the individual whose attacks occur chiefly during menstruation; the child whose seizures are induced by hyperventiliation may need to be encouraged to take up the piano or drums rather than the French horn.

Table 2. Factors which may precipitate seizures.

Menstruation
Hyperventiliation
Vitamin A toxicity
Anesthetics
Emotional trauma
Fatigue
Sleep
Constipation
Fever
Allergy
Startling sensations
Photogenic stimulation
Alcohol
Drugs

Assessment and Diagnosis

The diagnosis of seizure disorders is primarily a medical concern. However, the diverse symptomalogy of the epilepsies make all individuals who have significant contact with a child potential sources of valuable information. Diagnostic work has two major aims: the determination of the underlying cause of the seizures and the identification of the particular seizure type. Identification of the causes of a seizure disorder may allow the medical treatment of infection or the removal of toxins from the child's environment. The identification of seizure type also has an impact on treatment as seizure forms respond differentially to medical interventions.

The diagnosis of seizures in infants may be particulary difficult. The infant is unable to report what has occurred and the symptoms displayed may resemble many other possible conditions. Table 3 lists some symptoms which may in fact be seizures. The reader will note that many of these symptoms could easily be regarded as some illness other than a seizure disorder, especially in young children. Two of these are of particular note; staring episodes and crying spells (Knobloch & Pasamanick, 1974). Staring episodes may be attributed to daydreaming when, in fact, the child is experiencing a seizure. Obstructing the child's vision by placing and holding one's hand before the child's eyes will differentiate between staring and seizures. Even the very young child will react to visual obstruction by turning the head, smiling, or reaching for the hand, if staring, while the seizing child will not. Crying spells may also be indicative of seizure activity, particulary when those spells do not seem to be related to a stimulus event. Parents may report that the child has spells of normal crying in response to being wet or hungry or angry but also spells of crying which begin and end spontaneously and during which the child does not respond to the usual means of comforting. Cases such as this bear some investigation into possible causes for internal distress or the possibility of seizures.

Table 3. Symptoms which may in fact be seizures

- Excessive daydreaming or staring episodes
- Crying spells with spontaneous onset
- Fainting attacks
- Night terrors
- Sleepwalking
- Sudden motor weakness
- Complaints of seeing things (e.g., sparkling lights)
- Uncontrolled laughing spells
- Prolonged headaches
- Abdominal pains
- Frequent nausea
- Tingling or numbing sensations of the limbs
- Suspicion of blindness, deafness or insensitivity to pain
- Twitching, tremors, apnea or cyanosis especially in newborns.

Seizure classification

As an aid to diagnosis several different formal classifications of convulsive disorders have been proposed (Berg, 1982; Gadow, 1979) and an International Classification of Epilepsy has been adopted by the World Health Organization. The existence of varying classifications provides a degree of confusion and an understanding of the various forms of seizures is further confounded by the informal terms used by parents and professionals in describing seizures and seizure disorders. The school psychologist who receives information from a parent rather than from a medical source is another step removed from an already confusing situation. The classification which will be presented here (see Table 4) draws on a modification of the classifications of the International League Against Epilepsy and the World Health Organization (Delgado-Escueta, Treiman, and Walsh, 1983a). This classification of seizures is based on factors such as age of onset, EEG findings, clinical manifestations, epidemiology, and response to treatment. The resulting classification is far more refined than the simple distinction between grand mal and petit mal attacks that is held by many laymen. Table 4 outlines the classification system, the various terms used to denote seizure types and some of the clinical and electroencephalographic manifestations of each type.

Table 4. Classification of recurrent seizure disorders (epilepsies)

Classification	Associated terms	EEG and clnical traits
Primary generalized epilepsies		
Clonic-tonic-clonic	Grand mal Awakening grand mal Major motor Generalized motor	Awakening seizures triggered by fatigue or alcohol, two distinct confulsive phases separated by a 10-20 second tonic phase, 4-6 Hz spike-and-wave complexes or normal EEG interictally, 14-24 Hz spikes during seizures
Tonic-clonic	Grand mal Major motor generalized motor	Tonic phase followed by general convulsions, occasionally nocturnal only, Hz spike-and-wave complexes or normal EEG interictially, Hz diffuse rhythms during seuzires.
Absence		
Classical absence of childhood	Traditional petit mal Petit mal Simple petit mal Pure petit mal Simple absence Genralized absence Pyknoepilepsy	1 1/2 to 10 seconds unconscious staring, stereotyped automatism, 3 Hz spike-wave complexes
Absence of juvenile myoclonic epilepsy	impulsive petit mal	Clinically identical to traditional petit mal, 4-6 multi-spike and wave complexes, 8-12 Hz diffuse rythyms
Juvenile absense		Clinically identical; to traditional petit mal, 8-12 Hz diffuse rythyms
Myoclonic absence		3-10 seconds of unconscious staring, stereotyped automatisms, bilateral limb and trunk myoclonias, 4-6 Hz multispike-and-wave complexes
Myoclonus absence		8 seconds of unconscious staring, asymetrical myoclonias, reactive automatisms, 8-12 Hz diffuse rythyms

Myoclonic		
Myoclonic seizures without mental retardation	Doose's syndrome	Myoclonic, atonic, absence, and clonic-tonic seizures, synchronous, irregular 2-3 Hz and 4-6 Hz multispike-and-wave complexes
Juvenile myoclonic	Janz epilepsy Benign myoclonic seizures	Mild myoclonic jerks of neck and shoulder, awakening grand mal, absence in one-third' of cases, 4-6 Hz spike-and-wave complexes interictally, 16-24 Hz spikes during seizures.
Partial Epilepsies		
Simple partial	Rolandic epilepsy Minor motor seizures Autonomic seizures Abdominal seizures Hypothalamic seizures Epileptic equivalent	Contractions of one side of face and arm (rolandic), motor twitching, sensory percetions, or nausea, abdonimal pain and vomiting (autonomic), localized interictal spikes and slow waves, 16-30 Hz spikes during seizures
Complex partial		
Simple partial at onset followed by impaired consciousness and automatisms	Temporal lobe epilepsy	Highly variable automatisms; picking at clothing, chewing, lip smacking, etc., hallucinations, mood changes

Impairment of consciousness at onset with motionless stare followed by automatisms	Temporal lobe epilepsy	Automatisms as above
Impairment of consciousness at onset with complex motor automatisms	Frontal lobe epilepsy Somatosensory epilepsy Occipital lobe eiplepsy	Complex automatisms may include undressing, sudden walking or running, aggressive acts in response to attempted restraint
Impairment of consciousness with drop attack automatisms	Temporal lobe syncope	Loss of tonus results in falling by automatisms
Secondary Generalized Epilepsies		
Simple partial evolving to clonic-tonic	Jacksonian epilepsy March epilepsy	Simple partial behavioral manifestations progressing to grand mal
Infantile spasms	West syndrome Hypsarhythmia Propulsive petit mal Salaam seizures Jackknife seizures Jactitation Massive myoclonic seizures	Sudden violent flexion of trunk or abdominal musculature. West syndrome is characterized by spasms, hypsarhythmia and arrested psychomotor development. Slow high voltage waves, runs of spikes
Myoclonic astatic or atonic epilepsies	Lennox-Gastaut syndrome Petit mal variant Atypical petit mal Inhibition epilepsy	Psychomotor retardation is common in childhood onset. Head dropping or jackknife attacks. Injuries due to falls are common.
Progressive myoclonic epilepsies with dementia	Epilepsies of Lafora, Lundborg, Hartung, Hunt or Kuf	Mild mental dysfunction to incapacitating neurologic impairment with death possible.

Seizures can be divided broadly into three types: primary generalized seizures in which the first clinical and electroencephalographic changes indicate involvement of both hemispheres, partial seizures in which the first signs show involvement of an anatomical or functional system restricted to a part of one or both hemispheres, and secondary generalized epilepsies which begin locally in the brain but progress to involve both hemispheres. Partial seizures are further differentiated into two broad types: simple partial seizures during which consciousness is not impaired, and complex partial seizures during which consciousness is impaired.

Primary generalized seizures. The traditional grand mal and petit mal types as well as certain of the myoclonic epilepsies fall in this category. Delgado-Escueta et al. (1983a) state that almost all the epilepsies in this category are genetically transmitted and almost all genetically transmitted epilepsies are expressed as primary generalized seizures. Epilepsies of other types are primarily due to nongenetic insults to the central nervous system of the seizure victim. Also, as a group the primary generalized epilepsies are more responsive to treatment than the other forms of seizure disorder.

Grand mal seizures appear as the only type of attack in four to 10 percent of epileptic patients but appear along with other forms of seizures in over half of all forms of epilepsy (Delgado-Escueta, et al., 1983a). For this reason Gadow (1979) estimated that 80% of all children who suffer seizure disorders have grand mal attacks. Grand mal seizures are of two types. The clonic-tonic-clonic type begins with violent convulsive jerking of the entire body (clonus). A brief, 10 to 20 second, phase of muscle stiffening (tonus) follows during which consciousness is lost and then the clonic jerking resumes. Bowel and bladder control is often lost during a grand mal seizure. Normal swallowing is interrupted and saliva may flow from the child's mouth and sometimes vomitting occurs. Seizures generally last from two to five minutes and may be followed by a postconvulsive state of confusion, irritability or extreme fatique. Seizures of this type are often triggered by fatique, sleep deprivation or alcohol intake and often occur at awakening. These "awakening grad mal seizures" begin most frequently at puberty and are very responsive to drug treatment. In 85 percent of cases seizures stop with valproic acid treatment.

The second type of grand mal seizure is the tonic-clonic type which begins with a period of tonus followed by clonic convulsions. Drug treatment is highly successful in eliminating seizures or reducing their frequency. The clonic-tonic-clonic and tonic-clonic grand mal epilepsies have different long-term prognoses. In most cases of clonic-tonic-clonic epilepsy drug treatment must be maintained as 60 to 90 percent patients suffer a recurrence of attacks after medication is withdrawn. Seizures recur in only eight to 20 percent of patients suffering tonic-clonic epilepsy after medication is withdrawn.

Often, grand mal attacks of both types are preceeded by an aura. An aura is a sensory, behavioral or motoric "warning" which preceeds the seizure. The individual may have a twitch, feel dizzy, see "blinking lights", experience an off taste or smell or may become irrational. The aura may allow the individual time to avoid injuries which can be incurred by falling or colliding with dangerous objects by sitting or lying on the floor in an open space. The aura may also give teachers, parents and other caregivers a signal to begin appropriate action.

Grand mal attacks are generally self-limiting and of relatively short duration and many individuals are able to return to normal activities soon after an attack. Under these circumstances the seizure itself (the abnormal brain activity and bodily consulvions) does not pose a risk to health other than the danger of falls or collisions with sharp or solid objects. Under other circumstances, however, grand mal seizures do pose the greatest potential for dangerous, even life-threatening situations. Attacks may be much longer than normal, lasting up to an hour or more (prolonged grand mal), seizures may occur in rapid succession with only brief periods of consciousness between attacks (serial grand mal) or seizures may occur one upon another without consciousness being regained between seizures (grand mal status or status epilepticus). Each of these events represents a medical emergency. The dysfunctions such as breathing irregularties and loss of thermoregulation which are of lesser significance during a seizure lasting a few minutes may lead to brain damage or death when seizures are protracted.

Absence (nonconvulsive) seizures are far less common than the grand mal types. Absence seizures, including traditional petit mal, occur in three to four percent of patients with epilepsy. Classical absence (traditional petit mal) accounts for most of the cases of absence epilepsy. Attacks are characterized by a few seconds of unconscious staring and are sometimes accompanied by minor clonic, tonic, atonic or autonomic components (e.g., abdominal pain) as well as motor automatisms. Automatisms are seemingful purposeful behaviors such as chewing, lip smacking, blinking, walking about or picking at clothing that accompany certain seizure types. Automatism may be helpful in distinguishing epileptic attacks from daydreaming or inattentiveness. In nearly half of all patients with absence seizures other seizure forms eventually develop. The presence of these other seizure forms often aids in the recognition of absence spells as seizures.

The differentiation of the absence epilepsies by EEG traits and clinical signs is summarized in Table 4. Additionally, traditional petit mal differs from the other absence forms in prognosis. All the absence epilepsies have typical onset in childhood and adolescence but traditional petit mal disappears by early adulthood in almost all cases. The other absence forms persist into later life and require continued pharmacotherapy for control.

The primary generalized myocolonic epilepsies are characterized by convulsive jerking of muscles singly or in groups (myoclonias). Myoclonic seizures of early childhood may be expressed as myoclonic, atonic, absence or clonic-tonic seizures. Impaired psychomotor development does not occur in this form (Doose's syndrome) but does accompany some secondary generalized myoclonic opilepsies. Juvenile myoclonic seizures are often accompanied by awakening grand mal and absence attacks. Response to drug treatment is excellent in both the early childhood and juvenile forms of primary generalized myoclonic seizures but the rate of seizure recurrence is high when medication is withdrawn.

Partial epilepsies. Partial (focal) epilepsies are the most common form of convulsive disorder, occurring in two-thirds of patients with epilepsy. Approximately half of these patients suffer from complex partial seizures and half from simple partial seizures. The focal epilepsies generally indicate that some neurological insult has been suffered at the site where abnormal nerve discharge originates. In simple partial seizures the result of the abnormal discharge may be twitching of an arm or leg or the corner of the mouth. Occasionally the abnormal neuronal activity will spread to adjoining tissue. The convulsions progress to include more and more muscle groups and may culminate in a secondary grand mal seizure. These spreading convulsions, referred to as march or Jacksonian seizures, are rare in childhood.

Autonomic seizures are another form of simple partial attack. Symptoms may include abdominal pain, nausea, vomiting, headache, skin flushing, pupilary dilation and olfactory sensations. Seizures of this type are often followed by a postictal (postconvulsive) lethargic state. Autonomic seizures are considered to be rare in childhood but this may be because their symptoms are not recognized as being the result of seizures.

Rolandic epilepsy is a form of simple partial epilepsy which accounts for 15 percent of all childhood seizures. In contrast to the other partial seizure disorders rolandic epilepsy is transmitted genetically. Rolandic seizures often involve twitching of one side of the face and an arm and may interfere with speech when the tongue, pharynx and facial muscles are affected. Rolandic epilepsy is generally treatable with a single drug and tends to disappear by early adulthood.

The complex partial seizures begin locally within the brain and impair consciousness. This class of seizures is often referred to as psychomotor epilepsy, fugues epilepticus or temporal lobe epilepsy. Approximately 75 percent of the complex partial epilepsies do have a point of origin in the temporal lobe but the focus may be located in other brain structures as well. Complex partial seizures of temporal lobe origin often are preceeded by an aura of auditory sensations or vertigo and the first phase of the seizure is a motionless stare. Other sites are implicated by a lack of motionless stare at onset and auras consisting of visual or tactile sensations, autonomic symptoms and disturbances of mood or thought processes. Psychomotor seizures are often accompanied by automatisms. These automatisms may be simple, stereotyped behaviors such as blinking or swallowing but more complex automatisms such as sudden running or walking or swimming or bicycling movements may also be present. The complex partial seizures are often resistant to drug treatment.

Secondary generalized seizures. The secondary generalized epilepsies have focal origin which progresses to an attack involving both cerebral hemispheres. One form, Jacksonian seizures are often associated with significant organic pathology such as cerebral atrophy, toxoplasmosis and cytomegalovirus infections, tuberous sclerosis, phenylketonuria and other inherited metabolic disorders. These seizure types tend to be difficult to treat and carry poor prognoses. Mental retardation is common and in some forms progressive neuropathology may result in incapacitating disability or death.

Infantile spasms are characterized by violent myoclonic jerks of the trunk or back. Often the child doubles up (jackknifes) during the seizure. This condition is sometimes mistaken for colic and inappropriate treatment is instituted. Infantile spasms, hypsarrythmia (slow, high voltage EEG waves) and arrested psychomotor development comprise West syndrome. Treatment of West syndrome with adrenocorticotropic hormone (ACTH) has shown promise in controlling seizures but reversal of psychomotor effects is usually not achieved. West syndome often preceeds the development of Lennox-Gastaut syndrome, one of the myoclonic astatic epilepsies. In Lennos-Gestaut seizures often cause a sudden dropping of the head. The violent jackknife convulsions of West syndrome may also be present and protective headgear may be necessary. Occasionally the attack of a secondary generalized myoclonic epilepsy will take the form of a complete loss of muscle tone throughout the entire body causing the victim to suddenly drop to the floor. Response to treatment is often poor for the myoclonic astatic and atonic epilepsies.

The last class of seizures, the progressive myoclonic epilepsies with dementia carry an extremely poor prognosis. Developing in adolescence and adulthood, these disorders are the result of progressive neuropathological processes. Death is eventually caused in some forms and mental deterioration is almost certain. As in most of the secondary generalized epilepsies, multiple seizure types occur in these patients and response to treatment is poor.

Febrile seizures. One type of seizure disorder which is not included in the classification of recurrent seizure disorders merits attention, the febrile seizure. Febrile seizures occur in infancy and early childhood and are triggered by high fever. Seizures suffered by children who have a history of nonfebrile seizures and seizures in children whose fever is caused by intracranial infection are excluded from the definition of febrile seizure. In this way seizures induced by high fever in otherwise normal children are differentiated from fever-induced epileptic seizures and seizures resulting from infectious insult to the central nervous system. Seizures fitting this definition are often referred to as "simple" febrile seizures. Febrile seizures occur in approximately three percent of young children (Wallace, 1984). This makes febrile seizures the most common convulsive disorder of young children, accounting for nearly two-thirds of young children who experience seizures (Hirtz & Nelson, 1983).

Simple febrile seizures are associated with the common infectious diseases of childhood as well as with events which may produce fever such as immunizations. Approximately one-third of children who suffer a febrile seizure have recurrences of seizure. Convulsions of this type are usually similar in clinical manifestion to a generalized grand mal attack and are brief and self-limiting. A single seizure during an episode of high fever is the norm.

For most children the occurrence of a single simple febrile seizure does not appear to increase the risk of developing recurrent epileptiform seizures. However, risk of subsequent nonfebrile seizures increases if neurologic development was suspect prior to the seizure, there is a family history of epilepsy, the seizure is partial rather than generalized, the seizure lasts longer than 15 minutes or multiple seizures occur within a day. There is some question about the effect of febrile seizures on subsequent development (Wallace, 1984) but it appears that in the absence of risk factors besides the seizure itself psychoneurological impairment is unlikely (Hirtz & Nelson, 1983).

Psychoeducational assessment

Differential diagnosis. The medical classification of the seizure disorders can be important to the school psychologist. Knowledge of the diagnosis and its ramifications may allow the psychologist to gain an appreciation of the child's situation and the stressors which may be experienced by child, teachers and family. But, it is imperative for those who work with children with seizure disorders to understand that pinpointing a disorder within the complex classification system does no more than to set broad expectations for the individual. The medical diagnosis provides no shortcuts to careful assessment in the school setting and may present significant difficulties. A child in the author's caseload may be illustrative.

Mindy was referred for a general evaluation of special needs when she was in the eighth grade. At that time a recent transfer student into her present school district, she had suffered grand mal attacks since infancy and had been on medication virtually all her life. Control of seizures with medication was only partial and Mindy had attacks several times monthly. Mindy was referred due to poor peer relations, low self-concept, inconsistent effort in the classroom and poor organization of time and tasks. Assessment revealed reading and language skills at or above grade placement and math skills several years below grade. Her attention and effort during academic testing was very good but during an intellectual assessment she showed poor effort and attention and a Full Scale of IQ of 85 was the result. It was carefully noted that this score represented a minimum estimate of Mindy's ability. At that time services were provided through the school social worker and school counselor but Mindy was often uncooperative and little was accomplished. Several years later assessment was again requested. Psychoeducational information provided to the school by the Mayo Clinic indicated that academic skills had progressed very little since the previous assessment and two Full Scale IQ scores of 80 were reported. Mindy's peer completion was lacking, frequent breaking of school rules, time, was noted and school credits were inadequate for graduating with her class.

In Mindy's case the definition of individual needs was straightforward and uncomplicated but differential diagnosis was a murky issue. A case would be made for a learning disability (the difference between the highest estimate of ability and math achievement met the severe discrepancy criterion of Iowa guidelines), a behavior disorder, a mental disability or a physical disability. A learning disability label was never seriously considered as low math achievement was clearly only a small part of a much larger set of concerns. Even though each examiner strongly questioned the validity of their intellectual assessment a mental disability diagnosis was not rejected out of hand. It was felt that even if the IQ scores did not represent Mindy at her best they might reflect her typical condition. Central to the discussion by the diagnostic-education team was the role of Mindy's seizure disorder and its necessary treatment in causing or exacerbating her difficulties.

In the author's experience this chicken-and-egg issue has arisen frequently in the consideration of children with physical disorders. There is usually little question that there is something medically or physically wrong with the child but, as in Mindy's case, the nature and the extent of interference with the process of education is unclear. Specific guidelines for the identification of "physically disabled" children are not available in the State of Iowa and the literature on the effects of seizure disorders is not especially helpful.

In order to consider the research in this area it may be useful to differentiate between relatively normal children who suffer seizures and children who suffer seizures and also have other neurological impairments. Children suffering from West syndrome, Lennox-Gestaut syndrome and many children with cerebral palsy would fit in the latter group. When these two groups are not considered separately it is very obvious that seizures simply a significant risk of psychoeducational impairment. If we look at the relatively normal, seizure disordered children alone the risks are not so clear. Many studies rely on clinic populations alone for subjects (Stedman, Van Heyningen, & Linsay, 1982; Stores, 1978). This results in a preselected sample referred to seizure clinics for some reason which may make the case out of the ordinary. In these samples impaired intellect, academic achievement and behavior is frequently reported. Sample selection difficulties prevent us from determining with certainty the extent of educational, psychological and behavioral risk to epileptic children. One massive study conducted on the Isle of Wight (Rutter, Tizard, & Whitmore, 1970) was able to avert selection problems by including entire cohorts of children on the island. In this study 18 percent of children with uncomplicated epilepsy suffered from reading retardation compared to six percent in the general population. Even though rate of reading disability in epileptic children was three times the expected rate, 82% of the epileptic children remained unaffected. The conclusion that risk of difficulties in the school setting is greater for epileptic than nonepileptic children may be inescapable but this does not simplyfy the task of assigning a diagnostic level or aid in providing for the individual child's needs.

Psychosocial stressors. There are certain factors which may affect epileptic children and their families that bear consideration during assessment. Broadly speaking, children who suffer from seizure disorders are more prone to have feelings of anxiety, depression, and low self-esteem than their peers and this emotional unrest may be exacerbated by certain anticonsulvant drugs (Ferrari, Barabas, & Matthews, 1983). Their seizures may be extremely embarassing episodes which mark them as different than their classmates. They may take on feelings of guilt for the cost of their care and treatment and the strain it places on the family. Puberty and growth spurts of adolescence may result in the loss seizure control at a time when this may disrupt all-important peer relationships. The potential emotional costs of a seizure disorder make the careful assessment of self-concept and the manner in which family, teachers and schoolmates react to the child and to the seizures important aspects of working a referral of an epileptic child.

The adolescent victim of a seizure disorder faces another upsetting consequence. The Iowa Administrative Code requires that an individual be seizure-free for a period of six months before a driver's license or permit may be issued. The license may be issued then only if a physician certifies the seizure-free period and makes a recommendation favorable towards licensure. One exception is provided. If a physician's statement indicates that seizure occurence is strictly nocturnal the six-month requirement may be waived after the case has been reviewed by a medical advisory board. Individuals could appeal under extenuating circumstances (e.g., minor seizures always preceded by an aura) but the outcome is uncertain. Even in the event that a license can be issued the high cost of automobile insurance may be prohitive to the child and the family.

The child who suffers from a seizure disorder runs an increased risk of educational, emotional and behavioral difficulties. This generalization tells us little about a given child but may help to guide our search for means to assist the child, family and school personnel. The careful assessment of a broad range of factors is necessary to appreciate the special needs of the epileptic child referred to the school psychologist.

Intervention

Medical Intervention

As with diagnosis, treatment of the seizure disorder itself is primarily a medical concern and it is almost always attempted through the use of anticonvulsant medications. Biofeedback (Freeman, 1979), a special diet and behavioral interventions (Gadow, 1979) have shown some promise and a limited proportion of focal seizure patients are canidates for neurosurgery but virtually all patients who suffer recurrent seizures are medicated. Fifty percent of all children who have seizure disorders are rendered seizure-free by medication and another 25 to 35 percent experience reductions in severity or frequency (Gadow, 1979). In children suffering from certain seizure types up to 95 percent may have seizures eliminated by medication.

General consideration of drug side effects

It is the aim of the medical practitioner in prescribing medication to eliminate or reduce seizure activity while averting side effects due to the medications. Side effects of anticonvulsant medications fall into three categories: intoxication due to high drug levels which might include toxic effects on the liver or kidneys, common side effects that occur at normal dosages such as drowsiness, irritability, or sleep disturbance and idiosyncratic reactions that are unrelated to drug dosage such as skin rash or drug intolerance. In addition to the examples already cited side effects might include dizziness, nausea, slurred speech, headaches, hypersensitivity to light, impaired vision, gum disease, alterations in mood and behavior and even psychotic reactions. Side effects are often transient changes following drug introduction or dosage change but they may also be long-term alterations in physiology or behavior.

The task of reaching a level of medication in the blood serum which is effective against seizure activity (therapeutic) yet does not produce toxic effects has been made simpler by modern blood tests. Acceptable therapeutic ranges have been established for many medications and physicians attempt to place patients on dosages which will maintain serum levels in this range. Traditionally, dosages were increased until seizures were eliminated or toxic effects began to appear. Some physicians even felt that the presence of nystagmus, a common first sign of toxicity, was desirable in patients on anticonvulsant therapy (Trimble & Reynolds, 1976).

The many potential side effects of anticonvulsant drugs have led researchers to examine the potential for reducing both the dosage and the number of medications adminstered to seizure patients. Gradual reduction of dosage with the goal of eliminating all but the smallest amount required to maintain therapeutic effectiveness is attempted. This procedure may result in "withdrawal seizures" which are transient seizures due to the change in medication level. An increase in seizure activity due to insufficient therapeutic level may also result and reinstatement of the medication at its former level may be required. The procedure of gradual reduction is followed for each medication in turn until a minimal effective level of medication is reached. The results of several studies suggest that medication reduction may have positive effects both in terms of improved seizure control and improved psychological functioning.

Fischbacher (1982) attempted a systematic reduction of anticonvulsant medications administered to the patients under his care. Data on seizure frequency and patient wellbeing were collected. In 20 of the 36 cases it was possible to eliminate at least one medication from the patient's pharmaceutical regimen without compromising long-term seizure control. In four more cases it was possible to reduce the dosages patients received and maintain seizure control. Wellbeing was assessed in a measure of mood, alertness, sociability, activity and the frequency of some negative behaviors such as tantruming. The group of 20 patients for whom a drug was eliminated showed a 31% improvement on the wellbeing measure compared to 6% for the other 16 patients.

Giordani, Sackellares, Miller, Berent, Sutula, Seidenberg, Boll, O'Leary, & Dreifuss (1983) reported that an intensive diagnostic and therapeutic regimen resulted in the elimination of at least one medication for 63% of the patients in their study as well as seizure redction in 60% of the patients. The intervention included group and individual counseling, behavior modification and education as well as comprehensive diagnostistic assessment of the patients' medical condition and medication needs. A psychoneurological test battery was administered to patients on admission to the treatment program and at the first outpatient clinic visit an average of seven months later. Patients for whom one or more medications were eliminated from their drug treatment performed significantly better overall on the test battery than patients whose medication was not changed during the treatment phase. Measures of well established routines and knowledge such as spelling and vocabulary did not differ between groups but tasks requiring sustained attention, efficiency in novel learning situations, flexibility in thinking and motor speed and agility were performed significantly better by the drug-reduced group.

The results of the Giordani, et al. and Fischbacher studies suggest that many individuals who are medicated for seizure control might benefit from a reduction in medications. It is important to note that dose adjustment must be approached in a cautious and systematic fashion. An individual who has been seizure free for a long period of time on a given set of medications may suffer withdrawal seizures or be insufficiently medicated during dosage reduction. The psychological effects of renewed seizures should not be overlooked. The fact that dosage reductions are only attempted after a seizure-free period of several years (Delgado-Escueta, et al., 1983b) makes the adolescent a much more likely candidate for drug reduction than younger children. Consequences of seizure activity which may be particularly stressful to adolescents have been noted above. The patient's family may not be prepared to cope with increased seizure activity, the child's peer relations may suffer and a child's self-concept could be devastated when seizure control is even temporarily lost.

The seizures which occur during dosage reduction can be more severe than normal and status epilepticus is a possibility. The inpatient population where close monitoring and medical supervision was possible. It may also be the case that drug reduction may leave a patient with a level of medication that will maintain seizure control under normal ciruamstances but not a level which will protect the patient from seizures when stressed. Fischbacher reported that one patient who had been seizure free for years remained so when one medication was withdrawn but had a series of severe seizures when suffering from a respiratory infection.

Anticonvulsant medications

Folk medicine prevailed in the treatment of epilepsy for many years. Early American settlers used a curious plant, lacking in chlorophyl, called "Indian pipe" or "convulsion weed" to treat seizures (Runkel & Bull, 1979). Bromides were introduced in the 1850s and phenobarbital in 1912 and for many years these were the only two drugs available for the treatment of seizure patients. Scores of drugs are now known to possess anticonvulsive properties though only a few of these are frequently prescribed. Table 5 lists many of the commonly prescribed medications, their applications and some of their potential side effects. Only a few of the most frequently prescribed medications will be discussed in detail.

Phenobarbital. Phenobarbital and several related barbiturates are among the most frequently prescribed anticonvulsants. Until recently, phenobarbital was considered to be the medication of first choice in the treatment of many types of seizure disorder (Gadow, 1979; Pasamanick & Knobloch, 1974), particularly grand mal. Phenobarbital is virtually free from major systematic toxic effects but does carry some significant side effects. Unfavorable behavior changes, most notably sedation or hyperactivity, occur in 20 to 75 percent of children receiving phenobarbital treatment (Camfield, Chaplin, Doyle, Shapiro, Cummings, & Camfield, 1979). Changes in emotional state are also reported. Ferrari et al. (1983) suggest very strongly that serious psychological disturbance may be precipitated or enhanced by barbiturate treatment even at "safe" therapeutic levels.

Table 5. Anticonvulsant medications

Anticonvulsant type	Use	Potential side effects
Barbiturates Phenobarbital Gemonil (metharbital) Mebaral (mephobarbital)	Generalized Petit mal Focal	Restlessness, sleep disturbance, reduced concentration, drowsiness, and impotence and drug psychoses (primidone). Systemic complications rare.
Hydantoinates Dilantin (phenytoin) Mesantoin (mephenytoin) Peganone (ethotoin)	Generalized Focal Epileptic equivalent	Excessive growth of facial hair, thickening of facial skin, gum overgrowth, nystagmus, constipation, cerebellar deterioration after long-term therapy, drowsiness (mephenytoin), interference with vitamin D and K metabolism, teratogenic.
Succinimides Zarontin (ethosuximide) Celontin (methsuximide) Milontin (phensuximide)	Petit mal Occasionally myoclonic	Dyspepsia, motor unrest, agitation, paranoid psychoses.
Oxazolininediones Paradione (paramethadione) Tridione (trimethadione)	Refractory Petit mal myoclonic	Nausea, weightloss, drowisness, visual disturbances, hepatitis, grand mal attacks, hair loss, teratogenic.
Benzodiazepines Clonopin (clonazepam) Valium (diazepam)	Status epilepticus Myoclonic	Drowsiness, fatigue, anxiety, sleep disturbance, hallucinations, rage.
Others		
Depakene (valproic acid)	Grand mal Primary generalized myoclonic types Photosensitive epilepsy Absence with tonic-clonic	Nausea, vomiting, gastric disturbance, liver dysfunction, blood disorders, and, infrequently, tremors, hair loss, increased weight.
Tegretol (carbamazepine)	Generalized Myoclonic	Gastrointestinal disturbance, drowsiness, blood disorders

ACTH and corticosteriods	Secondary generalized myoclonic	Steroid therapy carries the risk of side effects too numerous to list
Atabrine (quinacrine)	Petit mal	Skin discoloration
Dexedrine (dextroamphetamine)	Petit mal and grand mal sleep seizures	Palpitation, restlessness, tremor, anorexia, gastrointestinal disturbance
Diamox (acetazolamide)	Grand mal Menstrual seizures	Drowsiness, loss of appetite, convulsions
Phenurone (phenacemide)	Refractory temporal seizures	Pronounced toxicity

To examine phenobarbital effects Camfield et al. (1979) conducted a study of children who were seen in a hospital emergency room for an intitial febrile seizure. Following the initial seizure children received either phenobarbital or placebo for a period of 12 months. Follow up interviews were conducted one, four, eight, and 12 months after the initial visit. Parents were asked to note any side effects and symptoms of hyperactivity, behavior change and sleep disburbance were noted in particular. Intellectual assessment was conducted at either the eight or 12 month follow up.

The placebo and drug groups did not differ intellectually but the children on phenobarbital who were tested after 12 months of treatment scored significantly lower than those who were tested after eight months on phenobarbital. The sample sizes were small but there is at least the suggestion that prolonged treatment with phenobarbital has a deleterious effect on intellectual performance. The phenobarbital group displayed significantly more nontransient behavior changes than the placebo group (20% vs. 3.3%). Daytime fussiness and sleep disturbance typically consisted of waking fully alert and ready for play for several hours in the middle of the night.

This study is an important one in the investigation of drug effects. Children selected had suffered a single simple febrile seizure and any child who suffered a recurrence during the 12 months of the study was eliminated from the sample. The children who remained were unlikely to be individuals in whom the seizure occurrence marked the development of an epileptic disorder. This factor is significant because in most studies it is impossible to separate the effects of the medication from the effects of underlying neuropathology because virtually all children who suffer recurrent seizures are medicated. The effects observed in the Camfield, et al, study are almost certainly the result of phenobartital treatment and not pathology or pathology and treatment interactions. Despite well documented side effects phenobarbital will continue to be a frequently prescribed medication because of its effectiveness in seizure contol and its low cost.

Primidone. Primidone (Mysoline) is also a frequently prescribed barbiturate. One of its metabolities is phenobartital so it shares many of phenobarbital's side effects. It does have the advantage of being a less sedating drug than phenobarbital so that some of the drowsiness common to phenobarbital use is avoided.

Dilantin. Dilantin has been proven effective in the control of seizures in forty years of use. Dilantin is a far less sedating drug than the barbiturates. System toxicity is uncommon but some rare, serious systematic disorders (Stevens-Johnson syndrome, pseudolymphoma, exfoliate dermatitis) may occur. The common, known side effects of Dilantin are shown in Table 5. One of the unusual side effects is an overgrowth of gum tissue. There seems to be an increased sensitivity to irritation and susceptibility to infection of the gums. Meticulous oral hygiene to prevent gum disease or loss of teeth should be stressed with those treated with Dilantin. Dilantin's low cost, effectiveness and because it can be given in a single daily dose make it the most frequently prescribed anticonvulsant. Blood serum monitoring is very important with Dilantin because its metabolism and elimination may vary 17-fold in the therapeutic range.

Valproic acid. Depakene (valproic acid) has fast become one of the most frequently prescribed anticonsulvants. First introduced in this country in 1978, valproic acid is now considered to be the drug of first choice in the treatment of clonic-tonic-clonic and tonic-clonic grand mal seizures, benign juvenile myoclonic epilepsy of Janz, myoclonic epilepsy in early childhood, photosensitive epilepsy and absence associated with clonic-tonic seizures. Valproic acid does not possess many of the common side effects of other types of anticonsulvants. It can be a gastric irritant but this problem is minimized when the drug is taken with a meal. The most serious side effect associated with valproic acid is liver toxicity which has resulted in death in some cases.

Tegretol and Zarontin. Tegretol (carbamazephine) is used primarily in the treatment of partial seizures. While there is no clear first-choice medication for seizures of this type Tegretol therapy may be attempted first to avoid the side effects of other medications (Delgado-Excueta et al., 1983b). Zarontin is prescribed almost exclusively in the treatment of petit mal attacks. It is generally ineffective in the treatment of other seizure types and its inclusion in a therapeutic regimen without clear signs of petit mal seizures is questionable.

ACTH. Adrenocorticotropic hormone (ACTH) and some related compounds have been used successfully to treat secondary generalized myoclonic seizures. The psychomotor impairment which often accompanies this seizure type is not usually affected by treatment and seizure control may be only temporary.

Other medical treatments

The ketogenic diet. The ketogenic diet is a high-lipid nuitritional regimen which has been shown to have some effectiveness in treating myoclonic seizures. The diet prescribes that the mass of fat in the diet should be four times the combined protein and carbohydrate mass. The benefits of the diet may not be long lasting in some cases but it does avoid the side effects of anticonvulsant medication.

Surgical intervention. When complex partial seizures or secondary tonic-clonic seizures have occurred for several years without control by medication, show no signs of remission and are of such frequency and severity to interfere with life anterior temporal lobectomy may be considered. Before such a serious step is taken the possibility that seizure control has not been established due to improper choice of medications, inadequate compliance with the treatment regimen, or factors such as stress or alcoholism must be considered. Also, EEG results must indicate that the seizure origin is in a localized area of the brain and surgery must be possible without undue risk of life or neurological deficit. Seizure control is obtained in 60 to 80 percent of patients undergoing surgery (Delgado-Excueta, et al., 1983b)

School psychological intervention.

The existence of an epileptic child in the school psychologist's caseload does not carry the implication for any clear course of action. The reasons that children suffering seizures are brought to the attention of a school psychologist will vary widely. Parents may have concerns for the intellectual, emotional and educational ramifications of a seizure disorder. Teachers or principals may refer a child reactively following an initial in-school seizure. School personnel may want inservicing of staff and education of schoolmates to better understand the seizure disordered child. Physicians, seeking to balance seizure control against detrimental side effects of medications, may wish objective information as a basis of decision-making. A child may even suffer a convulsive attack while in an individual testing session or while the school psychologist is in the classroom. Dealing with these various demands calls upon a wide range of skills of the school psychologist.

Seizure first aid. In the event that you are present when a major motor attack occurs keep in mind these rules:

1. Stay calm. You cannot stop a seizure once it has started and your reaction to a seizing child may have a significant effect on others, especially the child's peers. The child may stop breathing momentarily during the seizure but this is normal and you should not be alarmed.

2. If the child is upright, in a desk or chair ease him to the ground.

3. Clear the area of hard, sharp or hot objects. Try to prevent the child from striking anything dangerous but do not otherwise try to interfere with movements.

4. Turn the child's head to the side or roll the child to his or her side. This keeps saliva or vomitus from obstructing the child's airway.

5. DO NOT TRY TO FORCE ANYTHING BETWEEN THE CHILD'S TEETH. Seizing individuals do not swallow their tongues and attempting aid of this kind may only risk injury to the child's mouth or the caregiver's fingers.

6. Allow the child to rest after convulsions have ceased.

7. Alert the principal, classroom teacher or school nurse. If the child has suffered seizures in school before some procedure has probably been established for informing the parents, allowing the child to rest, providing fresh clothing if the child is incontinent during seizures, taking the child home if necessary, etc. Calling emergency medical personnel is not usually necessary but seizures lasting more than ten minutes do constitute a medical emergency and an ambulance should be called.

Besides being aware of this information the school psychologist may be able to pass these rules along to other caregivers.

Dealing with parents. The nature of the psychologist's contact with parents will vary greatly depending upon the point in time when the psychologist enters the case. A school psychologist might be contacted immediately after an initial medical diagnosis has been made or years after parents first became aware of the seizure disorder. When the psychologist's first contact with parents of a child with a seizure disorder comes long after the initial diagnosis the parents concerns will tend to be more specific and less affected by an early, intense emotional reaction to the child's medical problem. The feelings of the parent should always be a consideration but under these circumstances the situation will be less delicate than when seizures have just begun.

Shortly after an initial seizure parents may be very distressed and seeking to cope emotionally with the diagnosis. A primary concern of parents at this point is the potential effect of a seizure disorder on intellectual status (Hanson, 1984). Peer relations, the decision of what to tell important others and the effects of medications may also be causes for concern. In brief, the parents are seeking assurances that their child will still be normal for their own sake and the child's and for the sake of communicating with family and friends. As discussed above, it is difficult to specify the consequences of a seizure disorder or medications for a given individual. Previous individual psychoeducational assessment is commonly lacking and the parents may not want their child to be singled out for assessment. A frank discussion of possible consequences and of the information that might be provided through assessment is in order. If the parents do not want individual assessment the review of school data, classroom observation, sociometrics, teacher questionnaires and other indirect means may be necessary.

Outside organizations may be helpful in providing information on the specific disorder the child has, resources available to the family and educational materials. In some areas support groups may be operating to help the family cope with the stresses which accompany the disorder. Table 6 provides a list of national organizations which provide these types of services to individuals suffering seizure disorders and their families.

The parents of epileptic children may tend to provide an extreme level of protection (Ward & Bower, 1978) and epileptic children, boys in particular, tend to be more dependent than their agemates (Stores, 1978). This protective attitude is not unfounded. Normal childhood activities such as tree climbing, bicycling, or use of playground equipment may cause a great deal of apprehension among parents of children whose seizures cause loss of consciousness or motor control. The child may be embarrassed by the parents' attempts to ensure safety. The protection may be necessary but the means of providing it may need to be altered to accommodate the child's feelings. A boy may think that it is "babyish" to be taken to school by his mother but may look forward to a ride from his father. Properly informed siblings and peers may be able to watch out for the child as well as the parents.

A final extremely important factor in dealing with parents is terminology. Use the terms that the parents are comfortable using. They may use the words "fits," "spells," "attacks," or "tremors" to describe seizures. Their description of the disorder may be a poor recollection of a doctor's best effort at simplification. Remember, it is less important to be technically correct in talking with parents than to establish a working vocabulary that is understood by all. DO NOT use the term "epilepsy" unless the parents do. To many, this term carries the same kind of emotional impact as "cancer" or leprosy" (Ward & Bower, 1978). You may understand that "epilepsy" simply denotes any disorder with the symptom of recurrent seizures but the parents may not.

Medical liaison. An alteration in the course of a seizure disorder, the initiation of drug treatment and the change of medications may all have a significant impact on the child in the school setting but communication between physicians and schools generally leaves much to be desired. Concerns over the confidentiality of medical and school records inhibits the exchange of information, messages provided by parents or children are often incomplete and unreliable, the treating physician, especially in rural areas, may not be a local doctor, and physicians are often unaware of the type of information that could be provided through the schools. Bridging this gap in communication is usually not the clear responsibility of anyone. The school psychologist may be able to help by creating an awareness of this potential problem or by taking the initiative in obtaining parental permission for sharing information and contacting the physician.

Once communication is established among home, school and physician the school psychologist may be able to provide useful data for determining the appropriate balance between seizure control and medication side effects. The school psychologist may be the individual best suited to provide social, behavioral, and academic information. The decision is not a simple one. An otherwise normal child may require an extremely sedating drug regimen to control minor motor seizures of brief duration and no loss of consciousness. The seizures may seem insignificant in comparison to the drug effects but the child might perceive them as impediments to peer relationships. A child with a serious mental handicap may have the capability of acquiring significant vocational, self-help and independent living skills but learning may be seriously impaired by seizure medications. The psychologist may be able to help by making better informed decisions possible.

A final consideration regarding medical liaison concerns immunization. Iowa law allows school immunization requirements to be waived if a physician documents that there is some medical reason for altering the normal immunization sequence. It may be the case that at the time innoculations were due that a child had just begun experiencing seizures, a lapse in seizure control had occurred or the physician felt that the child's normal reaction to immunization might trigger seizure activity. If a child's immunization sequence has been interrupted it is important to make sure that protection from disease has not been unnecessarily delayed. Infants are particularly at risk. School immunization records are checked annually but no systematic checking is done until school entry. The disease which immunizations protect the child from are potentially devastating and the child who suffers seizures may be particularly vulnerable to the effects of a serious illness (Connor, Williamson, & Seipp, 1978).

Inservicing professionals. The school psychologist may be called upon to provide information to school personnel either informally or in an actual inservice presentation. In this situation the school psychologist should attempt to provide some basic information regarding seizure disorders, their treatment and potential educational ramifications. Detailed information about seizure classification and medications should be restricted to particular cases within the school. Correcting misconceptions that teachers and other professionals may have is an important goal. The importance of treating the child who suffers seizures in the same fashion as other children to the fullest extent possible should be stressed. Teachers should be made aware that projecting a positive attitude towards the child and dealing with seizures in a calm manner will have a beneficial effect on the perceptions of the child's classmates. It is also important to encourage school personnel to use the terms the child and family are accustomed to in discussing the child's condition.

Educating children. When a child's seizure control is not complete it is particularly important that schoolmates be made aware of the child's condition. Seizures may occur at times and in places where adult supervision is lacking such as on the way to school or in the restroom. Basic first aid and a system of prompt reporting should be emphasized. When peers are educated and prepared it will be possible for the child to go about in a less restricted, more normal manner than if close adult supervision is always provided. Every attempt should be made to educate children to the fact that the child who suffers seizures is not necessarily retarded or abnormal. The child's needs for post-seizure care and medications should be discussed with classmates. Adolescent peers should be made aware that alcohol consumption can be dangerous due to possible unfavorable interactions with seizure medications and a lowering of the seizure threshold.

Other "interventions". The use of behavioral interventions in seizure control is little stressed in the literature. Biofeedback and operant procedures have been attempted but the success of pharmacotherapy makes these approaches a distant second choice and one turned to most often when seizures are resistant to drug therapy. The interested reader is referred to Mostofsky and Balaschak (1977). Behavioral strategies may have a significant impact in dealing with noncompliance in drug routine. To the psychologist's advantage the target behavior and the goal of intervention are predefined by the physician's prescription and the school can exercise a degree of control over the child to assure compliance. Compliance difficulties at home and among older children will be the greatest challenge. Older children may be embarrassed by the need to take pills in school and making the physician aware of the problem may allow the planning of a dosage schedule which avoids school hours.

The needs of children who suffer seizure disorders may be many and varied. Meeting these needs may call upon the special skills and training of the school psychologist (assessment, counseling, consultation), but at times the school psychologist will be able to lend a hand by passing on information, prompting others to act, projecting calmness on anxious situations and in other small ways. The role of facilitator to bring together parents, teachers and medical personnel may be the most important role the school psychologist can fill (Delamater, Bubb, Warren-Boulton, & Fisher, 1984).

Monitoring Methods

Seizures are, by and large, noticeable phenomena. Pure, uncomplicated absence seizures are truly rare. This makes the noting and reporting of seizures a simple task. Still, there are some useful guidelines. It is probably best to refrain from using the child to inform the parents. Children are notoriously unreliable messengers and sending a note or giving them instructions to tell their parents may single them out from their peers in a way which is detrimental to self-concept. School personnel should inform the parents diretly and in a calm, matter-of-fact way. The parents will know whether or not there is a need to inform their physician so they should not be pushed to call their doctor.

The need for other forms of monitoring will vary from case to case. A seizure disorder may cause or complicate social, emotional, behavioral or academic difficulties. The psychologist should be aware of the potential need for a multifaceted approach to assessment and monitoring but a full discussion of all possible monitoring requirements is beyond the scope of this chapter.

Conclusions and Considerations

Dealing with the problems of children with seizure disorders will never be a frequent activity of the school psychologist. The number of children suffering recurrent seizures in a caseload of 2000 would be expected to be between 10 and 30. At least half of these will have seizures completely controlled by medication and another third will have seizures partially controlled. Many may be children with multiple handicaps in whom the seizure disorder is secondary to a constellation of other difficulties. In five years the author had significant contact with only three cases of children with seizure disorders. An informal survey of psychologists in the author's agency indicated that this is a typical situation.

Even though the numbers may be small there is a significant opportunity for the school psychologist to play a key role in helping the child with a seizure disorder. Because of the medical nature of seizure disorders and the misconceptions and ignorance that may surround them it is easy for educational personnel to put off the problem as "not their job". Indeed, no one will fault the psychologist who begs ignorance when the topic arises. One knowledgeable, sensitive individual can have a great impact on the life of the child who suffers a seizure disorder and that can be a school psychologist.

Table 6. National organizations providing services to victims of seizure disorders and related disorders

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Epilepsy Foundation of American
4351 Garden City Drive
Landover, MD 20785
(301) 459-3700

American Narcolepsy Association
P.O. Box 5846
Standord, CA 95304
(415) 591-7979

Amyotropic Lateral Sclerosis Society of America
153000 Ventura Boulevard
Suite 315
Sherman Oaks, CA 91403
(213) 990-2151

Friederich's Ataxia Group
P.O. Box 11116
Oakland, CA 94611

Muscular Dystrophy Association
810 Seventh Avenue
New York, NY 10019
(212) 586-0808

National ALS Foundation
185 Madison Avenue
New York, NY 10016
(212) 679-4016

National Head Injury Foundation
280 Singletary Lane
Framingham, MA 01701
(617) 879-7473

National Multiple Sclerosis Society
205 East 42nd Street
New York, NY 10017
(212) 986-3240

National Reye's Syndrome Foundation
426 North Lewis
Bryan, Ohio 43506
(419) 636-2679

National Spinal Cord Injury Association
369 Elliot Street
Newton Upper Falls, MA 02164
(617) 964-0521

National Reye's Syndrome Foundation
P.O. Box RS
Benzonia, MI 49616

Parkinson's Disease Foundation
Columbia University Medical Center
640 W. 166th Street
New York, NY 10032
(212) 923-4700

Support Group for Families of the Mentally Ill
A New Beginning
2405 39th Street
Missoula, MT 59801
(406) 251-2146

The Dystonia Foundation
425 Broad Hollow Road
Melville, NY 11747
(516) 249-7799

Tourette Syndrome Association
Bell Plaza Building
41-02 Bell Boulevard
Bayside, NY 11361
(212) 224-2999

Tuberous Sclerosis Association
P.O. Box 159
Laguna Beach, CA 92652
(714) 494-8900

United Cerebral Palsy Associations
66 east 34th Street
New York, NY 10016
(212) 481-6300

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Blackman, J. (Ed.) (1983). Medical aspects of developmental disability in children birth to three. Iowa City, Iowa: University of Iowa.

These two volumes do an excellent job of providing basic facts about seizure and convulsive disorders. They are valuable references of information for other medical and physical problems which occur among school children. They are well organized, readable and supply enough information for most purposes that the school psychologist or other educational personnel might have.

Delgado-Escueta, A. V., Treiman, D. M., & Walsh, G. O. (1983). The treatable epilepsies. The New England Journal of Medicine, 308(25), 1508-1514 (a).

Delgado-Escueta, A. V., Treiman, D. M., & Walsh, G.O. (1983b). The treatable epilepsies. The New England Journal of Medicine, 308(26), 1576-1584 (b).

This two article series is a very comprehensive up-to-date review of seizure classification, differential effects of seizure type and research into clinical side effects of the most common anticonvulsant medications. Their importance as a reference is their coverage of the topic and their currency.

Freeman, S.W. (1979). The epileptic in home, school and society: coping with the invisible handicap. Springfield, Illinois: Charles C. Thomas.

This volume is a very comprehensive, readable work. Much of its information is presented in an easy to follow question and answer format which make it particularly useful to the parent or teacher with specific questions or the professional working with them.

Gadow, K.D. (1979). Children on medication: a primer for school personnel. Reston, Virginia: Council for Exceptional Children.

This volume is a useful guide to understanding the use, effects and side effects of medications employed in treating seizure disorders. A glossary of related terms, a medication chart and the discussion of pharmacotherapy for other disorders make this volume an important reference.

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